

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please notify be-

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon answers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Hem 21 is marked, or Hem 18 shows any injury, or other trauma, avoid the medical treatment of these areas.

MEDICAL CERTIFICATION

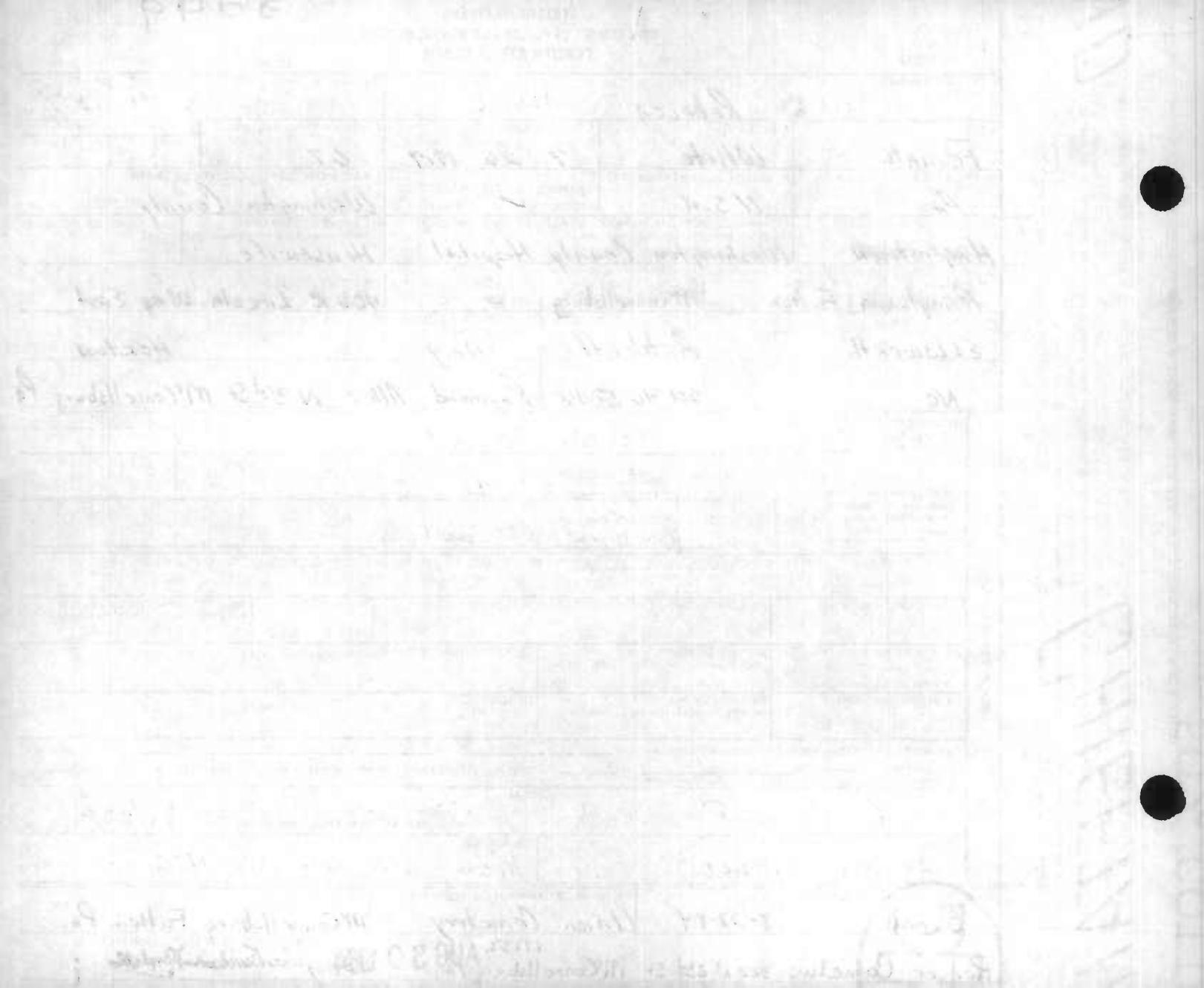
**1 - FOR
STATE
REGISTRATION**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23049

REG NO

1. DECEASED NAME (TYPE OR PRINT)			MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
ESTELLA <i>Rebecca</i>				ALLIER	8-23-84				12 33 1/2 M		
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			
Female	White	MONTH DAY YEAR			67			MONTHS	DAYS		
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Pa.		U.S.A.						<i>Washington County</i>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington County Hospital			Housewife			Gggyyy			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Pennsylvania Fulton		McConnellsbury						404 R. Lincoln Way East			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	
Ellsworth				Batdoerff	Mary					Horton	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
NO		201 46 5046			Raymond Alter			N. 3rd St. McConnellsbury Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bilateral Pneumonia</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Respiratory failure</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____ to _____ 19_____. that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											22c. DATE SIGNED
22b. SIGNATURE <i>Abdul Latif</i> DEGREE											ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						8/23/84			
ABDUL LATIF		1600 OAK HILL AVE HAG. MD 21740									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY		STATE
Burial		8-27-84		Union Cemetery			McConnellsbury		Fulton		Pa.
24. FUNERAL DIRECTOR NAME		ADDRESS			17233. AUG 30 1984			THE DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE			
Rodger Cornelius 322 N. 2nd St. McConnellsbury								Julie Johnson-Roselle			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 23 080

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Harold</i>	MIDDLE <i>Edwin</i>	LAST <i>Angle</i>	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR <i>8 18 84 3 1/4 PM</i>		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR <i>March 19, 1924</i>		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i>		MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>sheet metal</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>refrigeration</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>765 Spruce Street 21740</i>	
14. FATHER'S NAME FIRST <i>Ira</i>		MIDDLE <i>T.</i>	LAST <i>Angle, Sr.</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Etha</i>		MIDDLE	LAST <i>Gruber</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>217-12-2496</i>		17. INFORMANT ADDRESS <i>Mrs. Ruth V. Angle, Hagerstown, Maryland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Atherosclerotic Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>8/18 1984</i> to <i>March 19, 1983</i> , to <i>August 18, 1984</i> , that (I) (we) last saw the deceased alive on <i>8/18 1984</i> , and that in (my) (<input checked="" type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated above, (I) (<input type="checkbox"/>) (did) (<input checked="" type="checkbox"/>) view the body after death.									
22b. SIGNATURE <i>Mary E. Money, MD</i>		DEGREE				22c. DATE SIGNED <i>8/18/84</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mary E. Money, MD.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22e. ADDRESS <i>1708 Oak Hill Ave, Hagerstown, Md 21740</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Aug. 21, 1984		23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland		23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Maryland		25a. DATE REC'D. BY REGISTRAR 21 10 27 1984				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pender</i>			
DHMH - 16 50M 4/83 (VRA 15, 4)									



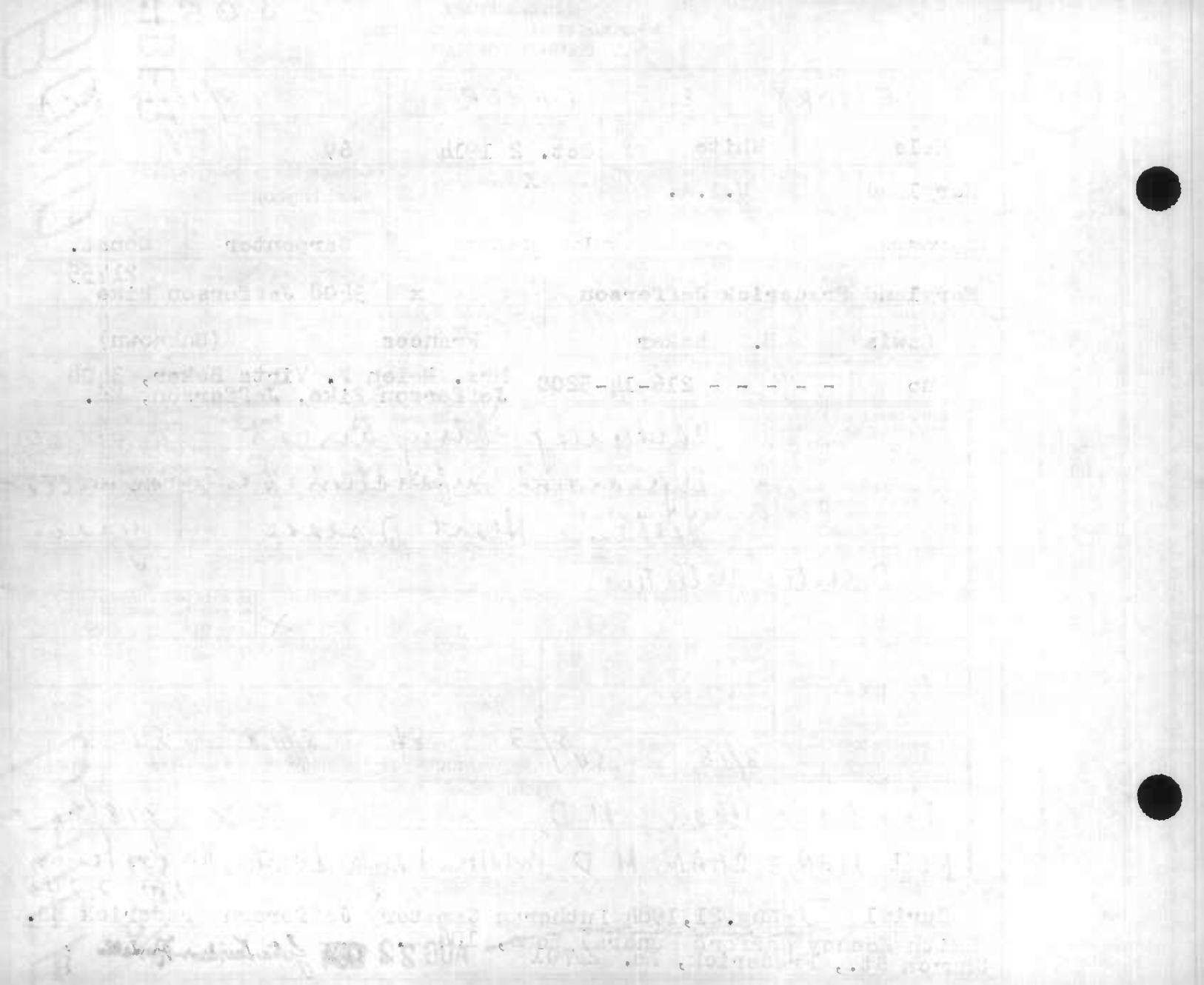
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												2 3 061				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
EMORY L. BAKER						8/18/84					8:00 AM					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male		White		Month Day Year Oct. 2 1914			69			MONTHS	DAYS	HOURS	MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Hagerstown		Western Maryland Center		Carpenter			Const.									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												21755				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Maryland		Frederick		Jefferson						3408 Jefferson Pike						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS								
		Lewis	H.	Baker	Frances			Mrs. Helen P. Virts Baker, 3408 Jefferson Pike, Jefferson, Md.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
no				216-14-5200						immediate						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												Causes respiratory arrest				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												due to, or as a consequence of				
{ (b) Hypocardial defarction, acute minutes												years				
{ (c) Ischemic Heart Disease																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																
Diabetes Mellitus																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/3/84 to 8/18/84, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/18/84, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (did) <input type="checkbox"/> (should) view the body after death.																
22b. SIGNATURE		DEGREE										22c. DATE SIGNED				
Rose Marie Chan, M.D.												8/18/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>										22e. ADDRESS				
ROSE MARIE CHAN, M.D.												Western Maryland Center, Hagerstown, MD 21740				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNT		23f. STATE				
Burial		Aug. 21, 1984		Lutheran Cemetery			Jefferson Frederick Md.			21740						
24. FUNERAL DIRECTOR		Smith Keeney Basford Funeral Home, Church St., Frederick, Md. 21701										25a. DATE REC'D. BY REGISTRAR				
												25b. REGISTRAR'S SIGNATURE				
												John Davidson Pendleton				

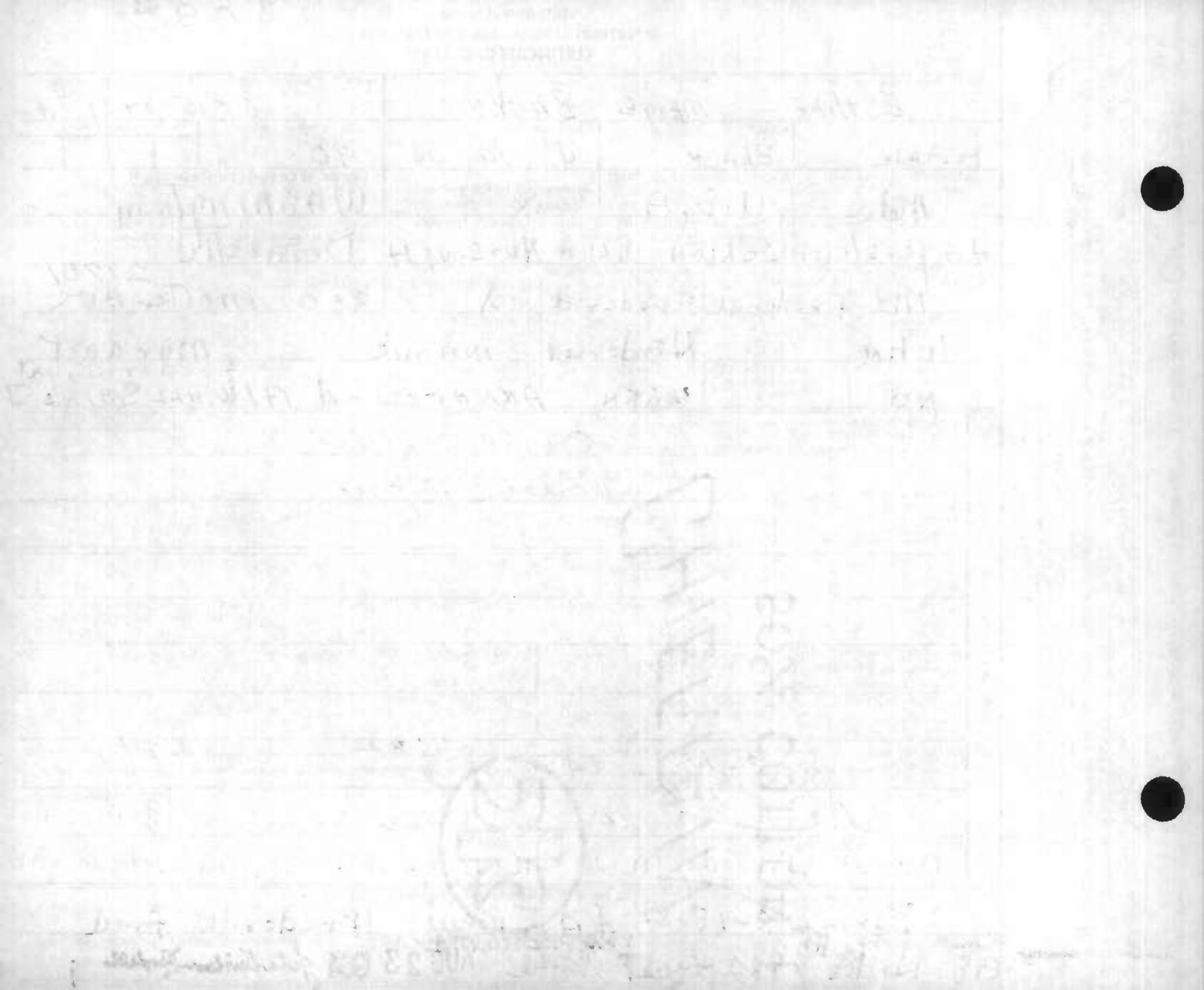


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be refiled by the hospital or attending physician.

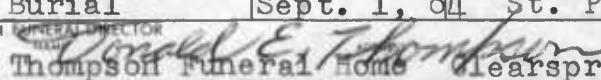
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

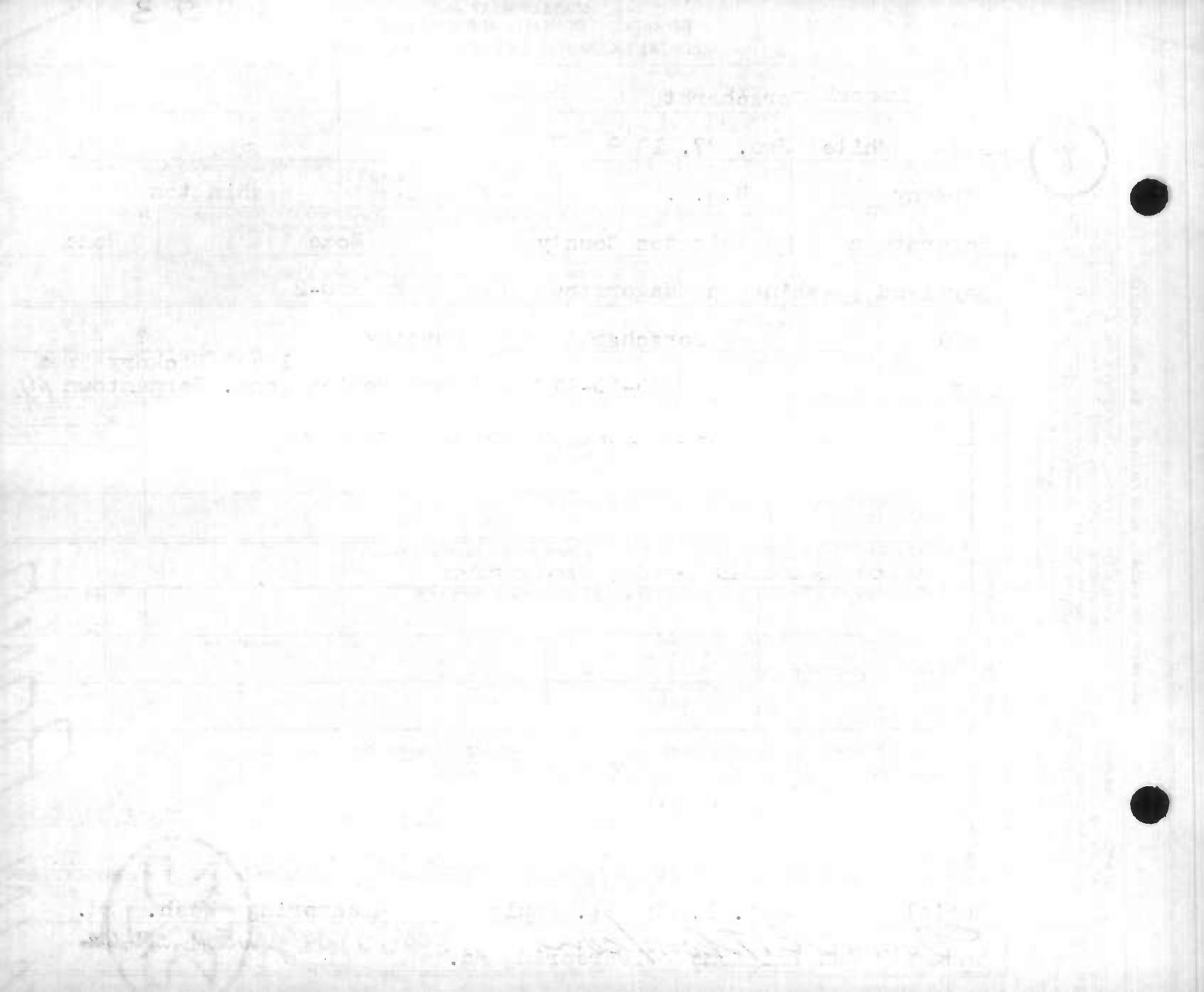
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23082													
												REG. NO.													
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR						
		<i>Esther</i>			<i>marie</i>			<i>Banks</i>						<i>8 - 15 - 84</i>		<i>804</i>	<i>A.M.</i>	<i>904</i>							
3. SEX		4. RACE			5. DATE OF BIRTH									6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
<i>Female</i>		<i>BLACK</i>			MONTH <i>4</i>			DAY <i>19</i>			YEAR <i>94</i>			<i>90</i>		<i>YRS.</i>		<i>MONTHS</i>		<i>DAYS</i>		<i>HOURS</i>		<i>MIN.</i>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?			9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORK)			12b. KIND OF BUSINESS OR INDUSTRY					
<i>Md</i>		<i>U.S.A</i>									<i>Hagerstown</i>			<i>Cottonville Nursing H</i>			<i>Domestic</i>			<i>MD</i>					
13a. STATE		13b. COUNTY			13c. CITY OR TOWN						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME								
<i>Md</i>		<i>Frederick</i>			<i>Frederick</i>						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			<i>800 Moller Ave</i>			<i>John</i>								
15. MOTHER'S MAIDEN NAME											16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
<i>Mamie</i>											<i>NO</i>			<i>unkn</i>			<i>ANNA HOLLAND</i>			<i>Cardiac arrest</i>					
19. DATE OF OPERATION		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			22a. DATE OF INJURY WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			22c. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>8-15</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.		22b. SIGNATURE <i>Abdul Waheed</i>			22c. DEGREE <i>M.D.</i>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>8-15-84</i>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>8-18-84</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Fredrick Fred</i>					
24. FUNERAL DIRECTOR NAME <i>C.E. Hicks III</i>			ADDRESS <i>Cyndy's View</i>			25a. DATE REC'D. BY REGISTRAR <i>Aug 23 1984</i>			25b. REGISTRAR'S SIGNATURE <i>Julie Saadon-Pardissi</i>																



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR USE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED				MONTH	DAY	YEAR	2b. HOUR	
Irmgard Borscharbt						Bosica	<input checked="" type="checkbox"/>				Aug. 27	1984	p.m.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	6. AGE IN YEARS LAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	2d. HOUR
Female		White		Jan. 27, 1929	58			<input checked="" type="checkbox"/>				Aug. 28	1984	45 p.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED				9. BALTIMORE CITY OR COUNTY OF DEATH			
Germany				U.S.A.								Washington			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown				Washington County				Home				Home			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS			
Maryland				Washington		Hagerstown		<input checked="" type="checkbox"/>				RFD-2 21740			
14. FATHER'S NAME FIRST				MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST				MIDDLE	LAST				
Karl					Borscharbt	Dorothy									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				1245 Hickory Tree			
No				538-36-1725				Thomas Bosica				Lane. Germantown (10)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of gastric contents (N-933)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
9/10 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												Sudden			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Suspected Alcoholism pending blood results															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								<input checked="" type="checkbox"/>				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE 												Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion			
												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER			
												DATE SIGNED 8/30/84			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS			
Howard N. Weeks, M.D.				580 Northern Ave., Hagerstown, Md.				Howard N. Weeks, M.D.				580 Northern Ave., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION CITY OR TOWN			
Burial				Sept. 1, 84				St. Pauls				Clearspring Wash. Md.			
24. FUNERAL DIRECTOR 								25a. DATE RECD BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Thompson Funeral Home								SEP 06 1984				John Davidson - Pendleton			

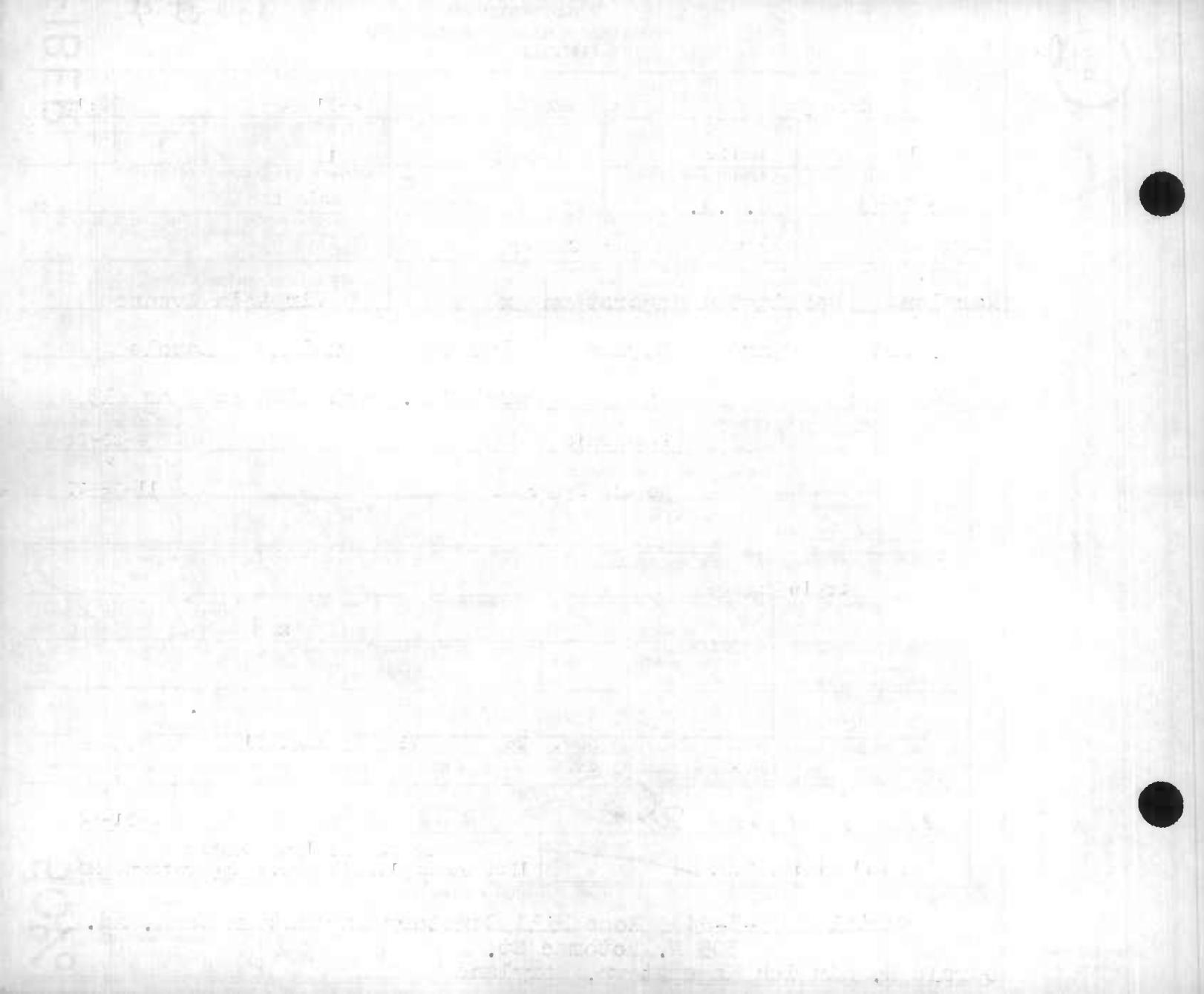


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23054	
												REG. NO.	
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
<i>B/1</i>			Cathyjo			BOWERS			8-31-84			8:15a.M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female		White		2-6-69			15 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		U.S.A.					Washington						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Western Maryland Center											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland		Washington		Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			739 Virginia Avenue 21740			
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			ADDRESS			
Robert		Edward		Bowers			Dorothy Lucille Lapole						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No								Pneumonia			8-23-84		
DUE TO, OR AS A CONSEQUENCE OF (b) Reye's Syndrome												11-26-73	
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b.													
Brain damage													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
19c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOV. 26, 1973, to Aug. 31, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug. 30, 1984, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (not) view the body after death.													
22b. SIGNATURE, M. Milaninia, M.D.												22c. DEGREE	
ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>												22d. DATE SIGNED 8-31-84	
22e. ADDRESS		Western Maryland Center 1500 Pennsylvania Ave., Hagerstown, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE			
Burial		9-5-84		Rose Hill Cemetery			Hagerstown Wash. Md.						
24. FUNERAL DIRECTOR NAME		305 N. Potomac St.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Gerald N. Minnich		Hagerstown, Maryland			SEP 6 1984								
DHMH - 16 50M 4/83 (VRA 15, 4)													



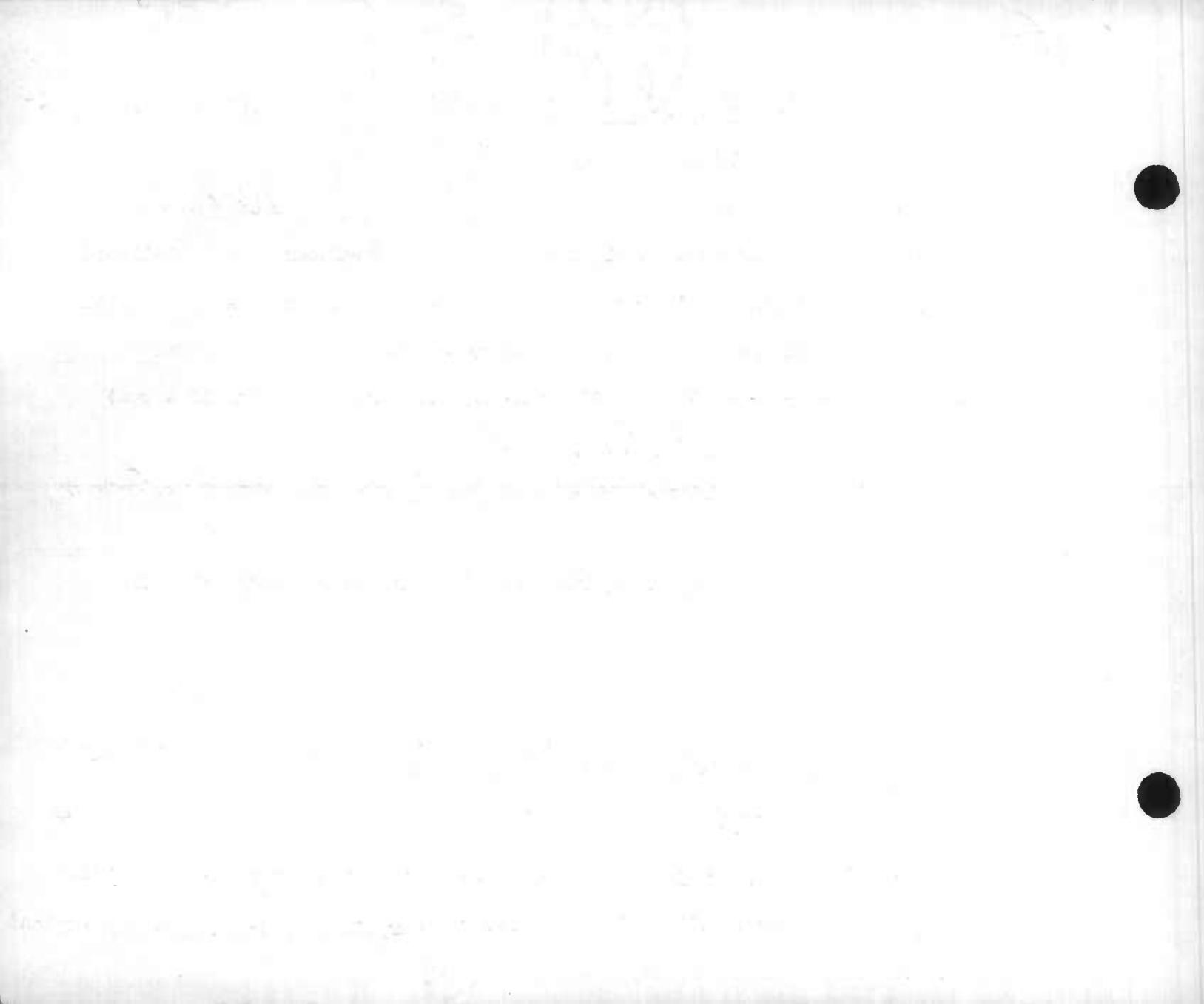
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, if signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma/even the medical examiner's report should be filed within 72 hours after death. Page 3 should be filed along with the medical examiner's report.

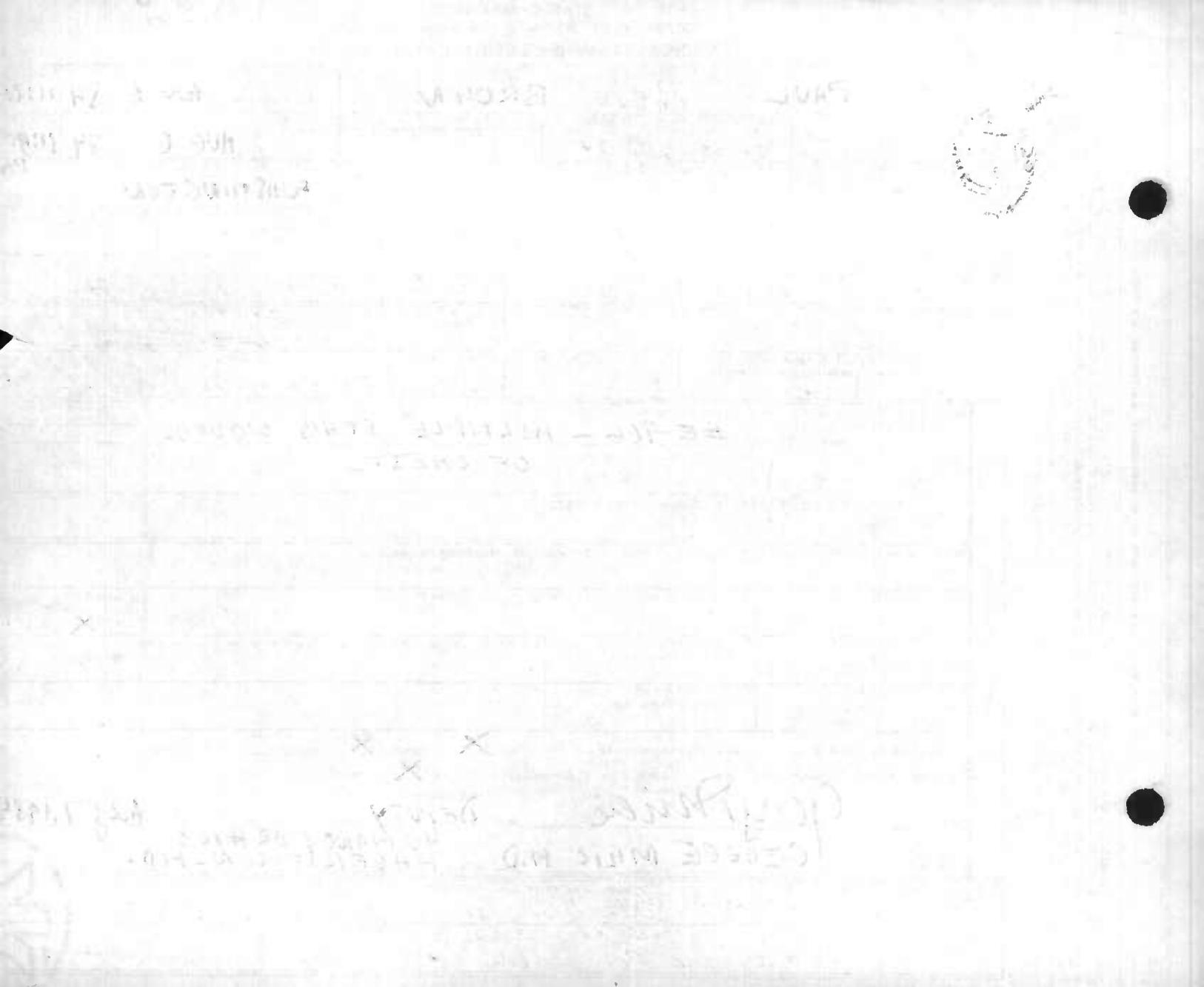
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23055			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d DATE OF DEATH MONTH DAY YEAR			2d HOUR 30 10PM				
Jacob Edgar Bowers						8 10 84							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male		White		May 6, 1915									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.						
Maryland		USA											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Hagerstown		Washington County Hospital		Engineer			Railroad						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Big Pool			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt. 1 Bx# 57A 21711			
14. FATHER'S NAME FIRST Oliver		MIDDLE Clinton		LAST Bowers			15. MOTHER'S MAIDEN NAME FIRST Mary Emma Catherine			LAST Baker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN) no		16b. SOCIAL SECURITY NO. -----		17. INFORMANT Dorothy L. Bowers			ADDRESS (item 13 above)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>													
(b) <i>Severe hypertension, chronic cardiovascular disease</i>													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Congestive Heart Failure, Diabetes mellitus, aortic insufficiency, Hypothyroidism</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 8/10		21f. LOCATION STREET CITY OR TOWN CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 8/3 1984 to 8/10 1984, saw the deceased alive on 8/10 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Allen W. Ditts</i>										DEGREE MD			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Allen W. Ditts MD</i>		22e. ADDRESS 1610 Oak Hill Ave Hagerstown MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/11/84						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 14, 1984		23c. NAME OF CEMETERY OR CREMATORIAL Blairs Valley Cemetery			23d. LOCATION CITY OR TOWN Clear Spring Maryland						
24. FUNERAL DIRECTOR NAME Major M. Osborne		ADDRESS Williamsport, MD 21795		25a. DATE REC'D. BY REGISTRAR AUG 20 1984									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN BUILDING 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 23056							
1. DECEASED NAME (TYPE OR PRINT)			FIRST PAUL			MIDDLE ReBIN			LAST BROWN			2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR AUG 6 1984		2b. HOUR 11:30			
1. SEX Male			RACE White			5. DATE OF BIRTH MONTH DAY YEAR 9-10-1959			6. AGE (IN YEARS LAST BIRTHDAY) 24 yrs.			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD AUG 6 1984		2d. HOUR 11:30 AM	
7a. BIRTHPLACE FOREIGN COUNTRY Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON Co.							
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Md. Correctional Institute			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None			12b. KIND OF BUSINESS OR INDUSTRY										
13a. STATE Md.			13c. CITY OR TOWN Octo.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 424 Ransay St.										
14. FATHER'S NAME FIRST Archie			MIDDLE Brown			15. MOTHER'S MAIDEN NAME FIRST Mary			ADDRESS										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. -			17. INFORMANT Dorothy J. Brown			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) #E-966 - MULTIPLE STAB WOUNDS DUE TO, OR AS A CONSEQUENCE OF OF CHEST - Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									2d. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE GEORGE MILIC		TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER EXAMINER'S NAME TYPE OR PRINT GEORGE MILIC M.D. ADDRESS 40 MANOR DR #103 HAGERSTOWN MD.										DATE SIGNED Aug. 7, 1984							
23a. BURIAL, CREMATION, REMOVAL burial			23b. DATE 8-11-1984			23c. NAME OF CEMETERY OR CREMATORY Bla. Home Cem.			23d. LOCATION CITY OR TOWN Bla. Burnie, Ga. Co. Ind.		23e. COUNTY STATE								
24. FUNERAL DIRECTOR John J. Cowan & Son, Inc. 901 Hollins St.			ADDRESS Bath Ind. 21223			25a. DATE REC'D. BY REGISTRAR AUG 14 1984			25b. REGISTRAR'S SIGNATURE Sylvia Davidson-Rendell										
DHMH - 17 (VR A15 ME (5)) 20M 4/82																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if any 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

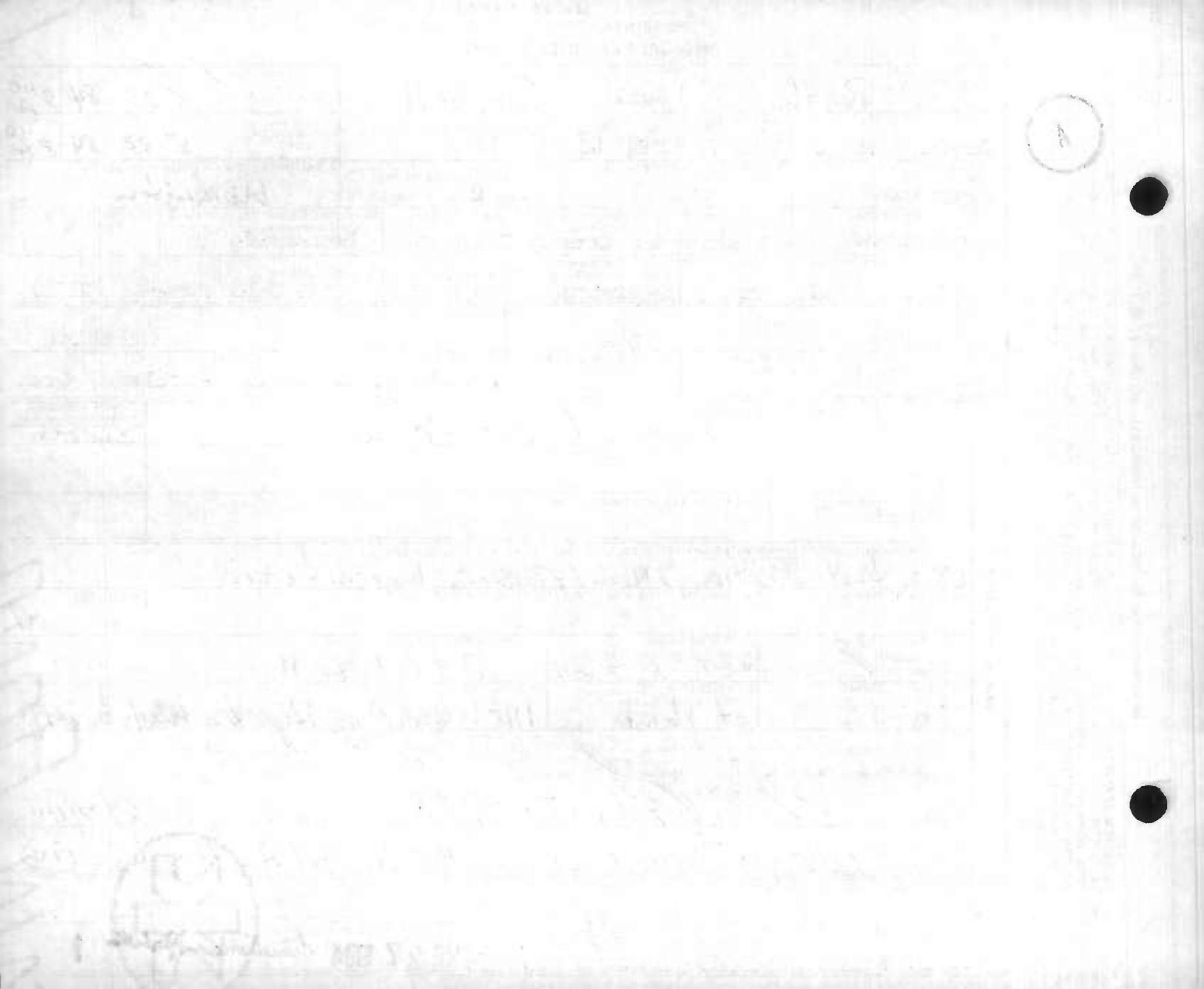
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23057	
												REG. NO.	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Julia Louise BYRD						August 30, 1984			9:20 AM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female			White			May 10, 1918			66 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Keedysville, Md.			U. S. A.						Washington				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Keedysville			Rfd. 1 Box 245			Housewife			Own Home				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
Maryland			Washington			Keedysville						Rfd. 1 Box 245 21756	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
John David Coffman			Lela May Line			219-20-4136			Mr. David O. Byrd,			Rfd. 1 Box 245	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiopulmonary arrest</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of endometrium</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (the hospital) attended the deceased from 3, 19 79, to Aug 30, 1984, that (I) (we) last saw the deceased alive on 6/18/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
George C. Newman, II, M.D.													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE	
George C. Newman, II, M.D.			1825 Howell Rd. Hagerstown, MD. 21740			Locust Grove Cemetery			Locust Grove, Wash. Co., Md.				
23a. BURIAL, CREMATION, REMOVAL SPECIFY: Burial			23b. DATE 9-2-84			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY	
24. FUNERAL DIRECTOR NAME: John H. Bast, Jr. ADDRESS: Boonsboro, Md. 21713									25a. DATE REC'D. BY REGISTRAR SEP 6 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Bast	

2-5-19 - Doreen Givens - Cognac - France - 2000

11. 11. 1962. 11. 11. 1962. 11. 11. 1962.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR OUR FILE.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 23058		
1- STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b HOUR			
Bertha		Belle	Campbell		<input type="checkbox"/>	8 22	1984	8 AM	8 40					
3. SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR	
female		white	Feb. 7, 1899	85 yrs.	MONTHS	DAYS	HOURS	MIN		8 22	1984	8 AM	8 40	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Hagerstown		USA					Washington							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital									housewife			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/>		1118 Salem Avenue		21740				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
Henry			Lum	Sarah				No					Donald G. Campbell, Portland, Ore.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured left femur.</u> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Oriental infection, atrial flutter, hypoglycemia</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>unknown 8 7 1984</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Patient fell</u>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>at Home</u>			21f. LOCATION STREET <u>1118 Salem Ave</u>		CITY OR TOWN <u>Hagerstown</u>		COUNTY <u>Washington</u>		STATE <u>MD</u>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		<u>Allen W. D. Ho</u> M.D. DO ASST										TITLE (SPECIFY) MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <u>1610 Oak Hill Ave Hyattsville MD</u>										DATE SIGNED <u>8/22/84</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
burial		Aug. 25, 1984			Rose Hill Cemetery			Hagerstown		Washington		Md.		
24. FUNERAL DIRECTOR NAME		MINNICH FUNERAL HOME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
415 E. Wilson Blvd., Hagerstown, Md. 21740								AUG 27 1984		<u>Julie Davidson-Rendell</u>				
BP														
DHMH - 17														
(VR A15 ME (5))														
20M 4/B2														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be notified or called.

MEDICAL CERTIFICATION

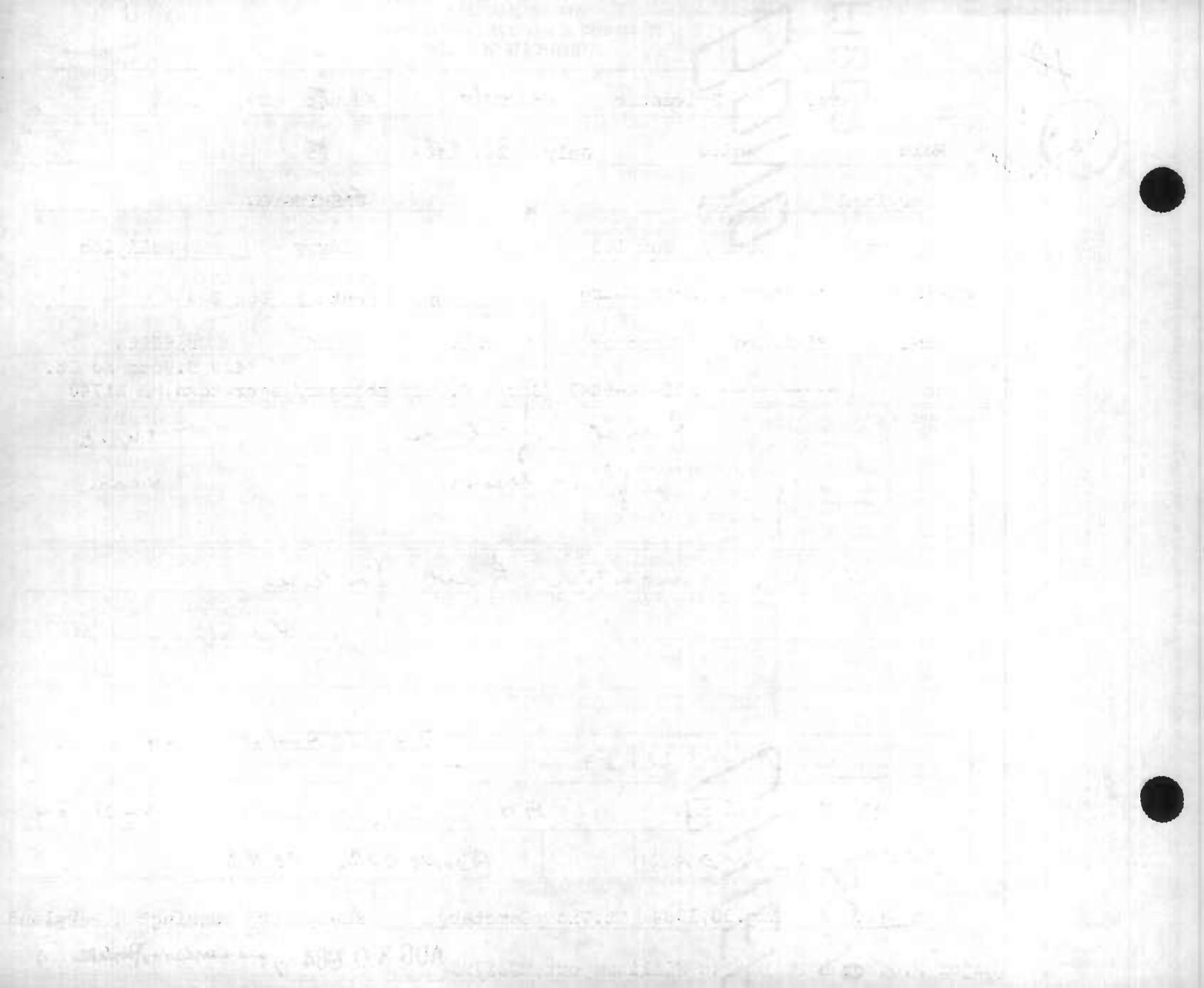
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23059					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
Charles Joshua Cavalier						8-17-84			8 45 AM						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
Male		White		9-14-1904			79								
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.								
W. Va.		USA													
10. CITY OR TOWN OF DEATH USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Hagerstown Maryland		Washington County Hosp.		Farmer			Farms								
13a. STATE 13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE								
Maryland		Frederick		Brunswick			719 Park Ave / 21716								
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO.			17. INFORMANT Jean Cavalier Mullen-Brunswick, Md.					
		Mary Kemp													
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost															
DUE TO, OR AS A CONSEQUENCE OF (c) Inflammation															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE DEGREE			22c. DATE SIGNED 8/17/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
Abdul Watherd am		600 Oak Hill Ave. HAG, MI 21740													
23a. BURIAL, CREMATION, REMOVAL SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE							
Cremation		8/17/84			Rosedale Crematory			Martinsburg, Berkeley, WV							
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Robert L. Spencer - Harper Ferry, WV								AUG 23 1984 John Dawson-Kendall							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 1 and 2 should be detached for use as the burial transit permit. Then please remit carbon copies. Pages 1 and 2 should be filed within 72 hours.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called in once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23060			
												REG. NO.			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Harry Sylvester CHURCHHEY						August 27, 1984						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.			
Male		White		July 26, 1889			95 YRS								
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			WASHINGTON MD.					
Maryland		USA													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY							
Sharpsburg		Route 1 Box 100			Clergy			Religion							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21782						
Maryland	Washington	Sharpsburg				Route 1 Box 200									
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
Otha Fillmore Churchey			Mary Ann Griffith			-----			215-44-9847			Sarah E. Poffenberger/Hagerstown, MD 21740			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week			
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												yours			
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) chronic congestive heart failure															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 74, to _____, 19 84, that (I) (we) last saw the deceased alive on _____, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.															
22b. SIGNATURE J. H. Huerta.			DEGREE 75			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-28-84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH SECUNDARI			22e. ADDRESS Boonsboro 21713												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 30, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery			23d. LOCATION CITY OR TOWN Sharpsburg Washington Maryland						
24. FUNERAL DIRECTOR NAME Major M. Osborne PO Bx#348 Williamsport, MD 21795			25a. DATE REC'D. BY REGISTRAR AUG 30 1984			25b. REGISTRAR'S SIGNATURE K. A. Rendell									

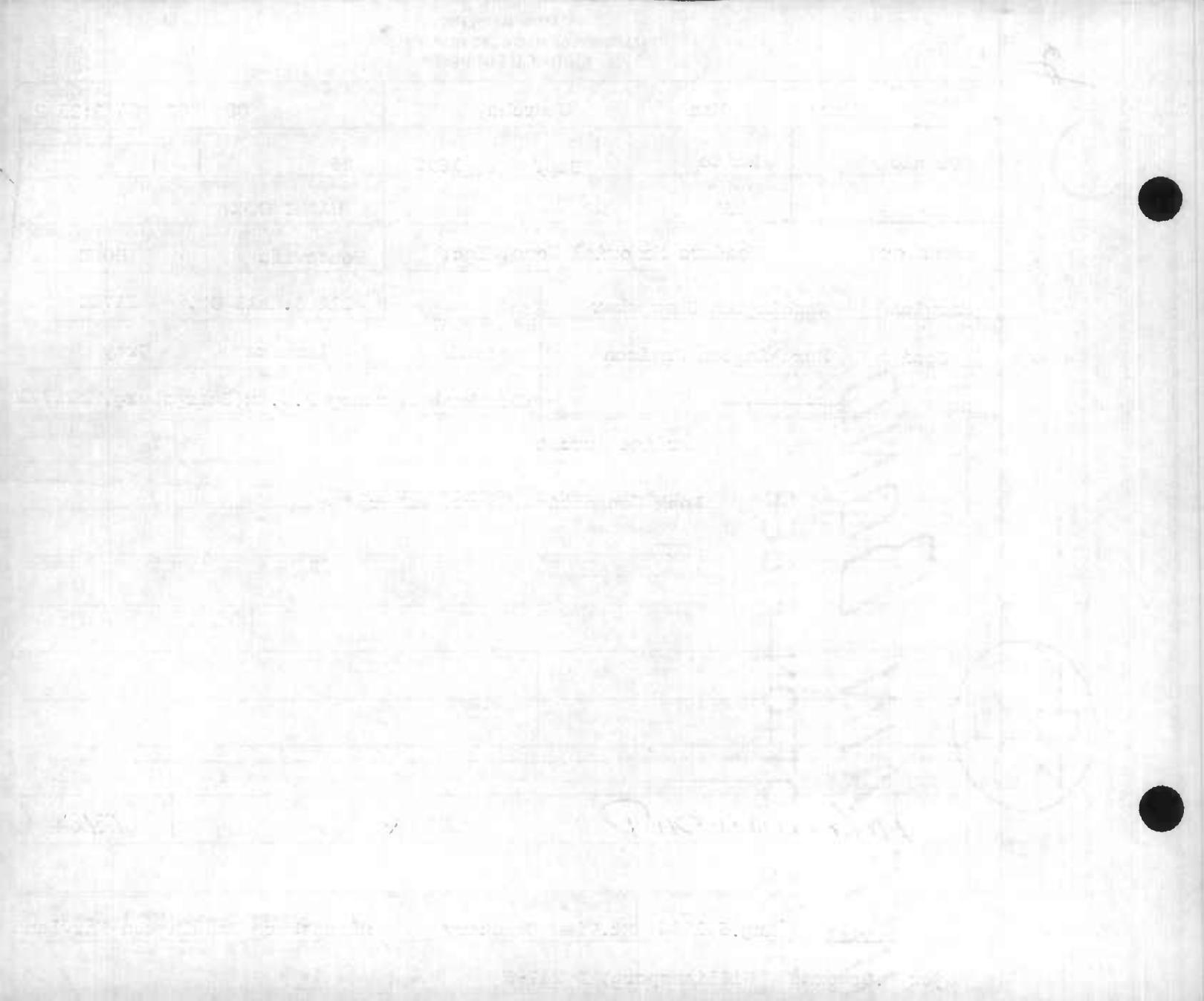


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign page 3
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23051					
1 - FOR STATE REGISTRAR			REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
Mary			Mae			Churchey			✓		08	02	84	3:25 P.M.			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			White			Sep. 8, 1897			86			MONTHS	DAYS	HOURS	MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8			9			BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			86			WASHINGTTON					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.					
Boonsboro			Reeders Memorial Home, Inc.			Housewife			HOME								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Washington			Sharpsburg			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			212 S.Hall St.		21782			
14 FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST			
Josiah			Worthington			Jamison			Minnie			Florence		Gray			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
no			-----			Clifford Churchey P.O.Bx#Sharpsburg, MD21782											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest																	
DUE TO, OR AS A CONSEQUENCE OF (b) Long Congestive Heart Failure																	
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>William M. Osborne</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/4/84								
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE Burial Aug. 5, 1984			23c NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery			23d LOCATION CITY OR TOWN Sharpsburg Washington Maryland			COUNTY STATE					
24 FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG 7 1984			25b. REGISTRAR'S SIGNATURE <i>Major M. Osborne</i>								
DHMH - 16 50M 1/B1 (VRA 15, 4)																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23062	
												REG. NO.	
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 30 3 AM	
Oneida E Clark						Oct. 12, 1907			8 11 84				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female			White			Oct. 12, 1907			76			YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Washinton MD.	
Brownsville, Md.			U. S. A.									Washington	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown			Washington County Hospital			Housewife			Own Home				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
Maryland			Washington			Hagerstown						921 Maryland Ave. 21740	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS	
William			Lena			No			213-72-8260			Mr. Clyde L. Clark, 921 Maryland Ave. Hagerstown, Md. 21740	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic squamous cell carcinoma of bladder									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
Hypercalcemia													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
19c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 8/10 1984 to 8/10 1984, that (I) (we) lost saw the deceased alive on 8/10 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Allen W. Detleffson			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/11/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen W. Detleffson						22e. ADDRESS 1610 Oak Hill Ave Hagerstown MD							
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 8-14-84			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash. Co., Md.				
24 FUNERAL DIRECTOR John H. Bast, Jr.			ADDRESS Boonsboro, Md. 21713			25a. DATE REC'D. BY REGISTRAR AUG 14 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson Pendleton				
DHMH - 16 50M 4/B3 (VRA 15, 4)													

卷之三

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 21 is marked if there was any injury, or other traumatic event, the medical staff must be notified in order to receive payment.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23063					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Samuel Allen Clark						August			17	1984		1:00pm			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		MONTH DAY YEAR February 8, 1941			43			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland		U.S.A.					Washington								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			NONE				
Hagerstown		Western Maryland Center			NONE			NONE			NONE				
13a. STATE MD		13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. 5, Box 376		21740					
14. FATHER'S NAME FIRST Samuel		MIDDLE W.		LAST Clark		15. MOTHER'S MAIDEN NAME FIRST Fannie		MIDDLE P.		LAST Dodson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) no -		16c. PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock		17. INFORMANT Mr. Samuel W. Clark, Hagerstown, MD 21740		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock				DUE TO, OR AS A CONSEQUENCE OF (b) Acute gastrointestinal bleeding								less than 24hr.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				DUE TO, OR AS A CONSEQUENCE OF (c) Duodenal ulcer								1975			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. End stage renal disease, on hemodialysis, mental retardation															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 9, 1978, to August 17, 1984, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on August 17, 1984, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did <input checked="" type="checkbox"/> view the body after death.															
22b. SIGNATURE Fe. U. Porciuncula, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/17/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 1500 Pennsylvania Avenue, Hagerstown, MD 21740													
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE Aug. 20, 1984		NAME OF CEMETERY OR CREMATORIUM Methodist Church Cem.		23d. LOCATION Chewsville, Wash., MD		CITY OR TOWN		COUNTY		STATE			
24. FUNERAL HOME Davis Funeral Home, Smithsburg, MD 21783		ADDRESS				25a. DATE REC'D. BY REGISTRAR AUG 28 1984		25b. REGISTRAR'S SIGNATURE Julia Laidon-Purcell							

X
A.C.

handwritten

FROM:

TO:

DATE:

196 NOV 1968

REMARKS:

RECEIVED

ON

mon

5

1968

CLOSED

LEWIS

DATE ON REVERSE SIDE OF ENVELOPE OR ON REVERSE SIDE OF CARD

-

ON

REMARKS: NO NORMAL MAILING
REMARKS: MAILING BY AIR MAIL

REMARKS: NO NORMAL MAILING

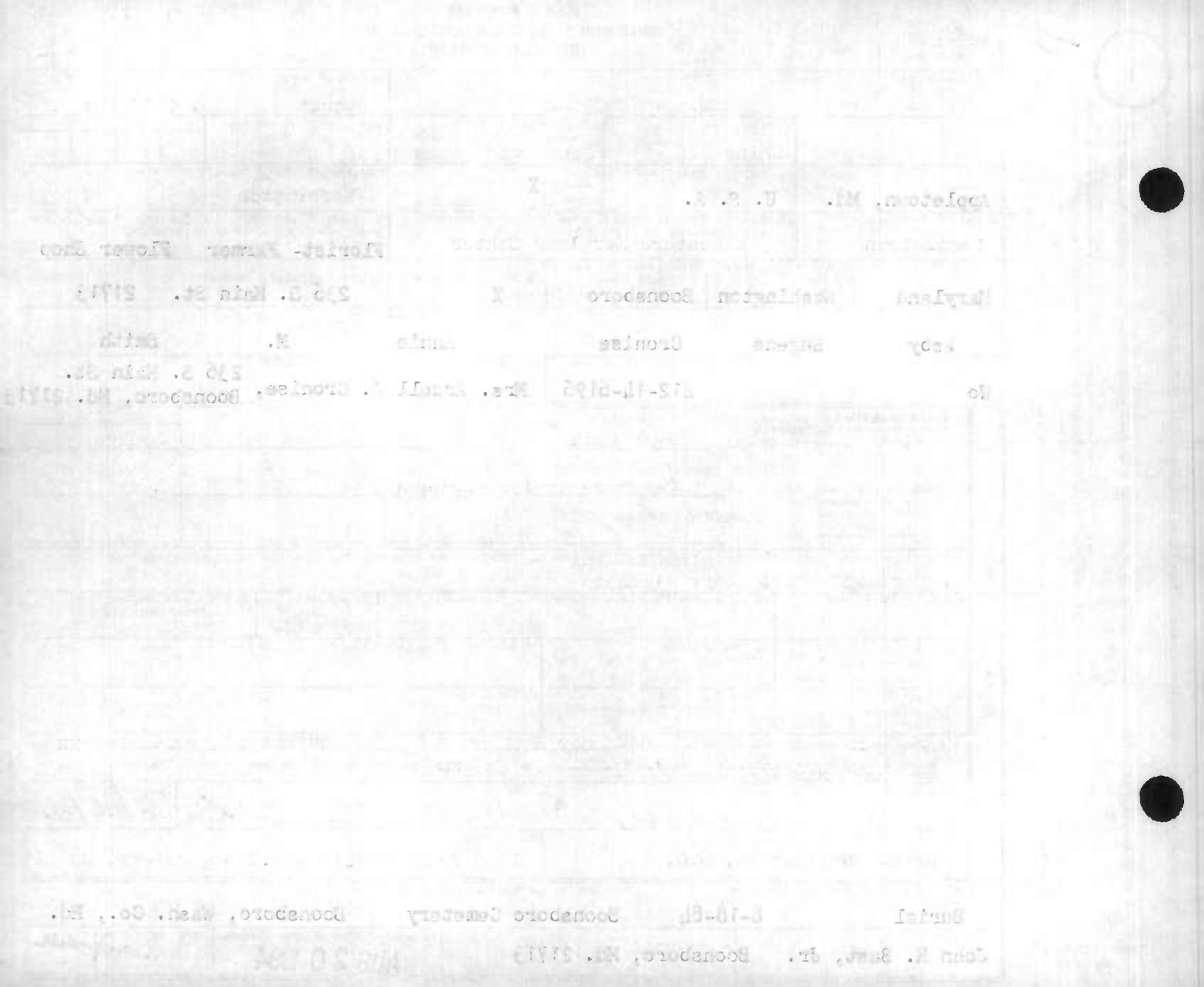
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23064					
										REG. NO.					
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
			Leo H. CRONISE						August		16, 1984			8:10a m	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White			June 28 1909			75		YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Appleton, Md.			U. S. A.						Washington MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Hagerstown			M Western Maryland Center			Florist- Farmer			Flower Shop						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland			Washington			Boonsboro						236 S. Main St. 21713			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Esby Eugene Cronise			Annie M. Smith												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			212-14-6196			Mrs. Ardell J. Cronise, Boonsboro, Md. 21713						3 days			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia															
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident April 1984															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic heart disease															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 1, 1984, to August 16, 1984, that <input checked="" type="checkbox"/> last saw the deceased alive on August 16, 1984, and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.															
22b. SIGNATURE Fe U. Porciuncula.			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED 8/16/84						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS												
Fe U. Porciuncula, M.D.			1500 Pennsylvania Ave., Hagerstpw, MD 21740												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-18-84			23c. NAME OF CEMETERY OR CREMATORIUM Boonsboro Cemetery			23d. LOCATION CITY OR TOWN Boonsboro, Wash. Co., Md.			STATE			
24. FUNERAL DIRECTOR John H. Bast, Jr.			ADDRESS Boonsboro, Md. 21713						25a. DATE REC'D. BY REGISTRAR AUG 20 1984			25b. REGISTRAR'S SIGNATURE John Ardell			

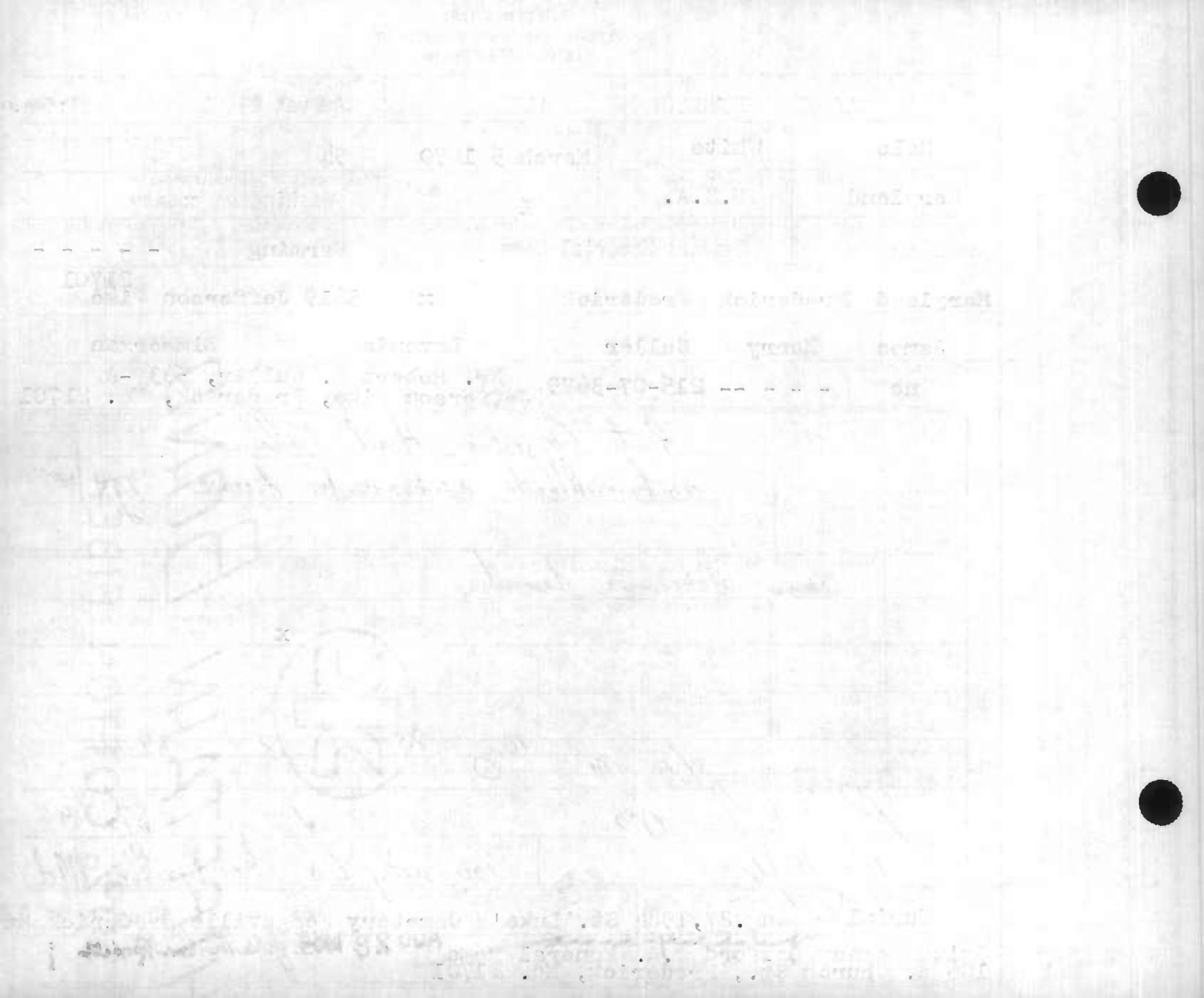


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered to use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or legend 21 is present, the injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												2306				
1 - FOR STATE REGISTRAR			REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR				
CLAUDE FRANKLIN CULLER						August 24, 1984						10:40a.m.				
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male			White		Month Day Year March 5 1890		94			MONTHS	YEARS	HOURS	MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			U.S.A.				Washington county									
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
Boonsboro			Reeders Memorial Home									Farming			-----	
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS		21701				
Maryland			Frederick		Frederick					5619 Jefferson Pike						
14 FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	Zimmerman				
James Henry Culler						Lavenia										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT MR. Robert L. Culler, 5639-A Jefferson Pike, Frederick, Md. 21701			ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
no			215-07-3679										24 hours			
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, 1c, & 1d.) PART 1. DEATH WAS CAUSED BY:			Acute Congestive Heart Failure													
IMMEDIATE CAUSE (a)																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			Due to, or as a consequence of (b) arteriosclerotic cardiovascular disease													
			Due to, or as a consequence of (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Severe Alzheimer's dementia																
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive <input type="checkbox"/> above, (I) (we) did <input type="checkbox"/> did not view the body after death.			22b DATE			10 83			to 8		19 84		that (I) (we) lost			
22c SIGNATURE R.L. Culler MD			22d DEGREE										22e DATE SIGNED 8/24/84			
22f PHYSICIAN'S NAME (TYPE OR PRINT) R.L. Culler			22g ADDRESS 100 Getty Ln Keedysville, Md													
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Aug. 27, 1984			23c NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery			23d LOCATION Feagaville			CITY OR TOWN		COUNTY		
														STATE		
24 FUNERAL DIRECTOR Smith Keeney Pasford P.A. Funeral Home 106 E. Church St., Frederick, Md. 21701																



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

B
5

signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed within 72 hours of death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

Film # G597 item 16b
FOR
1 - STATE 11/09/84 rja
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 23854

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR								
Cummings, Allen, L						8/28/84						6:15 P.M.								
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR								
MALE			Cau.			MONTH 12 DAY 16 YEAR 26			57 YRS.			IF UNDER 23 HRS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
Virginia			U. S. A.						Washington County											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Hagerstown			Washington County			Service Mgr.			Auto Sales											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE								
Maryland						Hagerstown						10 Fernwood Lane 21740								
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME														
Leslie			W.		Cummings	Dorothy														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			10 Fernwood Lane								
Yes			W. W. II 223-30-7723			Mrs. Margaret Cummings			Hagerstown, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Bronchogenic carcinoma</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Carcinoma</i> (c) <i>Hypoglycemia</i>																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <i>Abdul Wahab</i> DEGREE <i>cur</i>															22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>8/28/84</i>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN					
Abdul Wahab			1600 OAK HILL AV. HAG-MD 21740			Burial			Aug. 31, 1984			Shenandoah Mem. Park			Frederick County Virginia					
24. FUNERAL DIRECTOR NAME			ADDRESS			25d. DATE RECEIVED BY REGISTRAR			25e. REGISTRAR'S SIGNATURE											
James H. Fleming			WINCHESTER, VA			SEP 05 1984														

Wages | 2

adults 150 hours

100 hours

adults 150 hours

adults 150 hours

adults 150 hours

adults

adults

adults

adults

adults 150 hours

adults 150 hours

adults

adults

adults

adults 150 hours

adults 150 hours

adults

adults

adults

adults 150 hours

adults 150 hours

adults

adults

adults

adults 150 hours

adults 150 hours

adults

adults

adults

adults 150 hours

adults 150 hours

adults

adults

adults

adults 150 hours

adults 150 hours

adults

adults

adults

adults 150 hours

adults 150 hours

adults

adults

adults

adults 150 hours

adults 150 hours

adults

adults

adults

sfy

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												2 3 0 6 7				
												REG. NO.				
1- STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)															
HERBERT	FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED			2b. HOUR			
Souza							DAMAZO			<input checked="" type="checkbox"/> AUG. 6 1984			2:40PM			
3 SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.							2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	White	9 6 31	52 yrs.	MONTHS	DAYS	HOURS	MIN					AUG. 6	1984	2:40	PM	
7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON											
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown	Washington County Hospital											Pharmacist	MD.			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS	21758											
Maryland	Frederick	Knoxville		4936 Burkittsville Road												
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST											
Frank	Souza	Damazo	Christine		Cotter											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS													
No	013-25-5256	Ila Jane Damazo, Knoxville, Md. 21758	4936 Burkittsville Rd													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	#E-918 - CRUSHED CHEST ACCIDENT											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
9160																
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) SILO TOP COLLAPSE															
(c)	DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE	George Milic, M.D. TITLE (SPECIFY) EXAMINER'S NAME (TYPE OR PRINT)											DATE SIGNED AUG. 6 1984				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE											
Burial	8/10/84	Mt. Olivet Cem.	Frederick, Frederick													
24. FUNERAL DIRECTOR NAME	1621 ADDRESS	1621 Possumtown Pike	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE												
G. Douglas Stauffer, Frederick, Md. 21701			AUG 14 1984													

100-100-200 X 0540000 -23050H

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23008		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Lena K. Davis						10	16	32	8	4	84	11:20 A.M.		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female			White		MONTH	DAY	YEAR	51			MONTHS	DAYS		
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS			
Rose Hill, Va.			US		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington			MONTHS			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Hagerstown			Western Maryland Center									12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS ZIP CODE			
Md			Wash		Boonsboro			YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	8 Moteldin Drive 21713				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Hillary					Cupp	Susie					Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			295-26-8929			Mrs. Debora Routzahn,			8 Mc Keldin Ave. Boonsboro, Md. 21713			Mawles		
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												Cachexia		
DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell carcinoma of cervix												years		
DUE TO, OR AS A CONSEQUENCE OF (c) COPD														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN					
22a. I certify that (s) (this hospital) attended the deceased from saw the deceased alive on above, (s) (we) did <input type="checkbox"/> view the body after death.			22b. DEGREE			22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS			22g. ADDRESS			22h. ADDRESS					
Lynn S. Hees			1500 Pennsylvania Avenue Hagerstown, Md. 21740			Boonsboro Cemetery			Boonsboro, Wash. Co., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-7-84			23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery			23d. LOCATION CITY OR TOWN					
24. FUNERAL DIRECTOR NAME John H. Bast, Jr. Boonsboro, Md. 21713			25a. DATE REC'D. BY REGISTRAR AUG 1 1984			25b. REGISTRAR'S SIGNATURE								
DHHM - 16 50M 4/83 (VRA 15, 4)														

18 100

ETTS

monday

100 miles 0.5

ETTS left independence, minibus 1000, am 0501-29-200

100 miles back

ETTS left independence

ETTS left independence

100 miles

ETTS

ETTS left independence, am 0500, 100 miles back, 100 miles

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 showing any injury, or other traumatic event, medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23069			
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST		August 8, 1984			10:45AM		
Scully N.M.N						DeLucia							
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR # UNDER 24 HRS		
						Sept. 4, 1903		80 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey			7b. CITIZEN OF WHAT COUNTRY? U.S.A			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington			AD.		
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Carnival				
13a. STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 2401 Eutaw Place 21217		
14. FATHER'S NAME FIRST Anadio			MIDDLE			LAST DeLucia		15. MOTHER'S MAIDEN NAME FIRST Alimensina			MIDDLE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 225-10-5425			17. INFORMANT Mrs. Florence A. Fallane			ADDRESS Belleville N.J.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24-48 hours			
DUE TO, OR AS A CONSEQUENCE OF (b) Parkinson's Disease										Many years			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Peripheral Vascular Disease, Multiple Decubitus Ulcers													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (X) this hospital attended the deceased from July 16, 1984, to August 8, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 8, 1984, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> did <input type="checkbox"/> view the body after death.													
22b. SIGNATURE Fe U. Porciuncula			22c. DEGREE M. D.			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			DATE SIGNED Aug. 8, 1984				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fe U. Porciuncula, M. D.			22e. ADDRESS 1500 Pennsylvania Avenue Hagerstown, MD 21740										
23a. BURIAL, CREMATION, REMOVAL Cremation			23b. DATE Aug. 13, 84			23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory			23d. LOCATION CITY OR TOWN Smithsburg, Wash., Md. COUNTY STATE				
24. FUNERAL DIRECTOR Davis' Funeral Home			25. REGISTRATION Smithsburg, Md.			25d. DEATH CERTIFICATE REGISTRAR John L. Johnson			25e. REGISTRATION John L. Johnson				

SEARCHED INDEXED
SERIALIZED FILED
SEARCHED INDEXED
SERIALIZED FILED

SEARCHED INDEXED SERIALIZED FILED
SEARCHED INDEXED SERIALIZED FILED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the funeral-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23070					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
<i>Virginia Mae Dennis</i>							<i>8-18-84</i>						<i>0145 M</i>				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS				
female		white		<i>April 20, 1918</i>			66			MONTHS			DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			MD.				
<i>Virginia</i>		USA					<i>Washington</i>			<i>Hagerstown</i>			<i>Washington</i>				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
<i>Washington County Hospital</i>												<i>housewife</i>					
13a. STATE <i>Maryland</i>												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>902 Lanvale St. 21740</i>		
13b. COUNTY <i>Washington</i>				13c. CITY OR TOWN <i>Hagerstown</i>													
14. FATHER'S NAME FIRST <i>George</i>				MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>Mittie</i>			MIDDLE	LAST	<i>Scott</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No				<i>218-26-7301</i>			<i>Betty Powell, Hagerstown, Md.</i>						<i>MONTHS.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for items (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												<i>Abdominal Carcinomatosis</i>					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												(b)					
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION <i>2-7-84</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Abdominal pain</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>7-26</i> , 19 <i>84</i> , to <i>8-18</i> , 19 <i>84</i> , that (I/we) lost saw the deceased alive on <i>8-17</i> , 19 <i>84</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we did/did not) view the body after death.												22c. DATE SIGNED <i>8-18-84</i>					
22b. SIGNATURE <i>Eldon Haubak</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>			23b. DATE <i>Aug. 22, 1984</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Rose Hill Cem.</i>			23d. LOCATION CITY OR TOWN <i>Hagerstown, Wash., Maryland</i>			COUNTY	STATE				
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>			ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Md. 21410</i>			25a. DATE REC'D. BY REGISTRAR <i>AUG 27 1984</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodell</i>								

2002 77-21-8

A

incub.

Hypothalamic Cerebral vessels

X

Hypothalamic GM

0 77-21-8

77-21-8

0

77-21-8

77-21-8

X

77-21-8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

B
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial permit. Then please return carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23071	
1 - STATE REGISTRAR				REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST Wavie	MIDDLE Marie	LAST Diabo			2a. DATE OF DEATH		MONTH August	DAY 1, 1984	YEAR M	2b. HOUR:	
3. SEX female		4. RACE white			5. DATE OF BIRTH MONTH Oct.			YEAR 3, 1914			6. AGE (ENTER LAST BIRTHDAY) 69 yrs.		
7a. BIRTHPLACE COUNTRY West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY Potomac Tower					
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. FATHER'S NAME Edward		15. MOTHER'S MAIDEN NAME Leatha Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 16c. INFORMANT Doanne Rettig, Hagerstown, Md.			17. ADDRESS 11 W. Balt. St. Apt. 907								
18. CAUSE OF DEATH (Enter only one cause per line for Part I, in kind.) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)												APPROXIMATE TIME OF DEATH BETWEEN ONSET AND DEATH 3-4 hrs	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b)													
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED						21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21, PART I (b) PART 2)								
23a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		23b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			23c. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
27a. I certify that (I) (this hospital) attended the deceased from now until his/her death on Aug. 4, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We did not see the body after death.)													
27b. SIGNATURE Robakley		27c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			27d. DATE SIGNED 8-4-84					
23e. BURIAL, CREMATION, REMOVAL burial		23f. DATE Aug. 4, 1984			23g. NAME OF CEMETERY OR CREMATORIAL Cemetery			23h. LOCATION CITY, TOWN		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md.		ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG 7 1984			25b. REGISTRATION NUMBER John Landon Rendell i					

sch

2018/11

8

ter describir

los más

de interés

J

E

M o r o

Hijo

de santo

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transport permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical certification must be completed.

MEDICAL CERTIFICATION

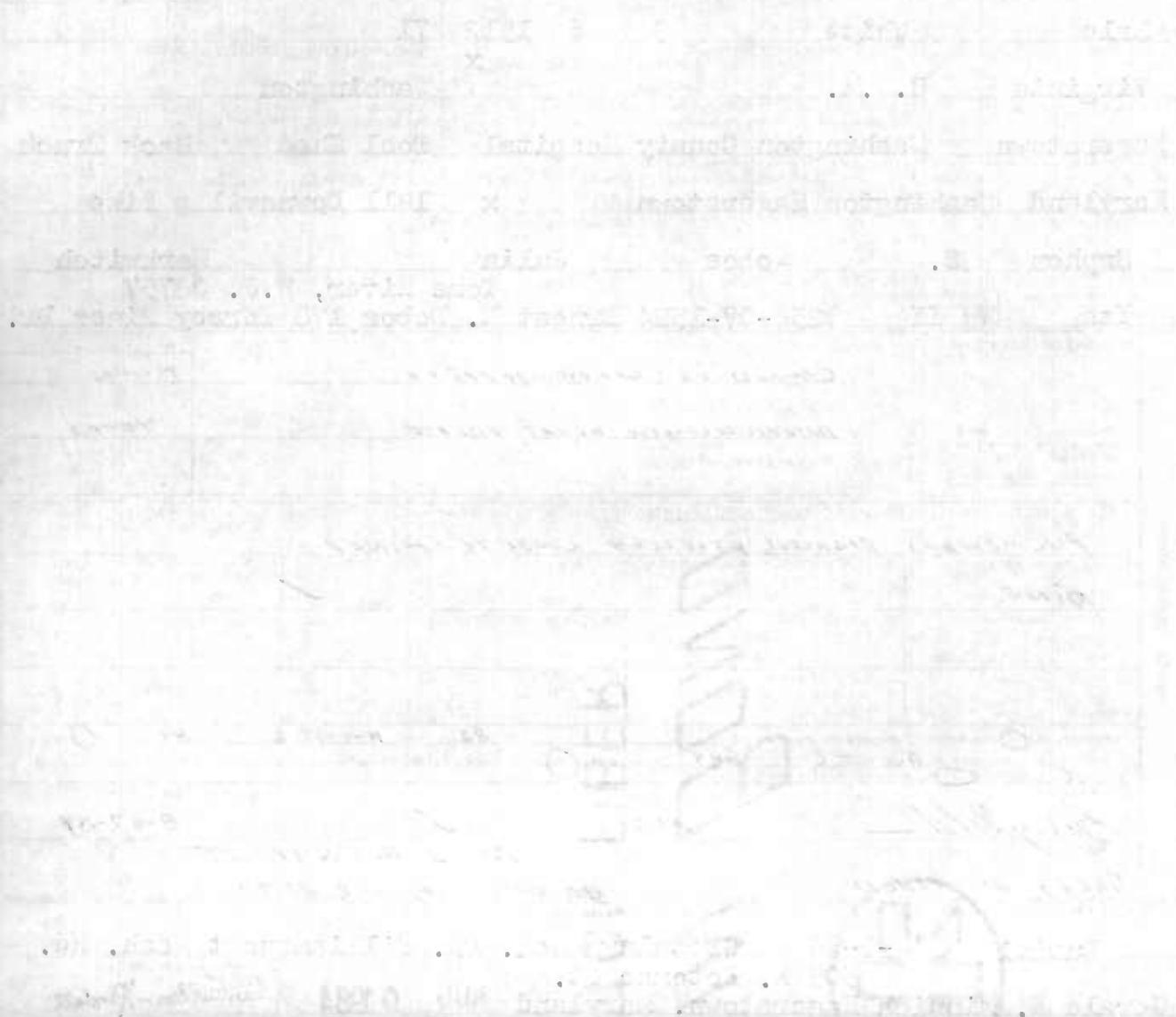
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 23072									
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<u>William Paul Dobos</u>									<u>August</u>	<u>7</u>	<u>1984</u>			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR			IF UNDER 24 HRS		
<u>Male</u>		<u>White</u>		MONTH <u>9</u> DAY <u>6</u> YEAR <u>1912</u>			71		MONTHS			HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			MD.	
<u>Virginia</u>		<u>U.S.A.</u>					<u>Washington</u>			<u>Hagerstown</u>			<u>Washington</u>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13a. STREET ADDRESS / ZIP CODE			12b. KIND OF BUSINESS OR INDUSTRY			10. CITY OR TOWN OF DEATH		
<u>Washington County Hospital</u>			<u>Tool Shed</u>			<u>1811 Downsville Pike</u>			<u>21740</u>			<u>Mack Truck</u>		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			10. CITY OR TOWN OF DEATH	
<u>Maryland</u>		<u>Washington</u>		<u>Hagerstown</u>										
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		ADDRESS			10. CITY OR TOWN OF DEATH	
<u>Stephen S. Dobos</u>						<u>Julia</u>				<u>Toms River, N.J. 08757</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE CARDIOMYOCARDY</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<u>Yes</u>		<u>WV II</u>		<u>236-07-1384</u>			<u>Ernest K. Dobos</u>		<u>178 Torrey Pines Dr.</u>			<u>MONTHS</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		{			18b. <u>ARTERIOSCLEROTIC HEART DISEASE</u>						<u>YEARS</u>			
DUE TO, OR AS A CONSEQUENCE OF		{			18c. <u></u>									
20 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a		{												
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
<u>NONE</u>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. LOCATION STREET			CITY OR TOWN		COUNTY				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		STATE				
22a. I certify that (this hospital) attended the deceased from <u>1982</u> to <u>1984</u> , that (we) last saw the deceased alive on <u>AUGUST 6 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did not) view the body after death.														
22b. SIGNATURE					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
<u>Barry M. Cohen</u>					<u>MD</u>			<u>339 E ANTETAM ST</u>		<u>8-07-84</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS			CITY OR TOWN		COUNTY				
<u>Barry M. Cohen</u>					<u>HAGERSTOWN, MD. 21740</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		STATE					
Burial		<u>8-9-84</u>		<u>Greenlawn Mem. Pk.</u>			<u>Williamsport Wash. Md.</u>							
24. FUNERAL DIRECTOR NAME		305 N. Potomac St.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
<u>Gerald N. Minnich</u>		<u>Hagerstown, Maryland</u>			<u>AUG 9 1984</u>			<u>Julia Davidson Pendell</u>						

DHMH - 16 50M 4/83
(VRA 15, 4)

ASSEMBLY DRAWING

SECTION A-A

VIEW 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23073		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR		
EMORY P DRAPER						AUG 8 1984						10 40 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		Month Day Year March 5, 1929		55			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			YRS.		
Hagerstown, Md.		U. S. A.		8					Washington			MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Washington Hospital				Agent			Insurance					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland		Washington		Boonsboro					Rfd. 1 Box 188			21713		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST					
		Harry	Hawbaker	Draper	Harriet			Catherine	Showman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT			ADDRESS					
Yes		1951-1952				Mrs. B. Lorraine Draper, Boonsboro, Md.			Rfd. 1 Box 188					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Cardiogenic Shock + Electrical Mechanical Dissociation immediate</u>														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiogenic shock + Pulmonary Edema</u>												12 hrs		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Myocardial Infarction</u>												16 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (INTERNAL OR INJURY IN ITEM 18 PART I OR PART 2)		21d. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)												
22a. I certify that (I) (this hospital) attended the deceased from 7-23, 1984, to 8-8, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												22c. DATE SIGNED 8-8-84		
22b. SIGNATURE <u>W S Hood</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W S Hood</u>				22e. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED 8-8-84					
23a. BURIAL, CREMATION, REMOVAL IS IT Burial		23b. DATE 8-11-84		23c. NAME OF CEMETERY OR CREMATORIAL Mountain View Cemetery		23d. LOCATION IN OR OUT TOWNSHIP SHARPSBURG, Wash. Co., Md.			25a. DATE REC'D. BY REGISTRAR AUG 13 1984			25b. REGISTRAR'S SIGNATURE <u>Jean Davidson-Pandale</u>		
24. FUNERAL DIRECTOR NAME John H. Bast, Jr. Boonsboro, Md. 21713		ADDRESS												

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 20 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23014

1 - FOR STATE REGISTRAR			REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			FIRST Ruth	MIDDLE E.	LAST Dwiggins	2a. DATE OF DEATH			MONTH 8	DAY 31	YEAR 84	2b. HOUR 8 4% M				
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH Sept. DAY 10, YEAR 1911			6. AGE (IN YEARS LAST BIRTHDAY) 72			IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Washington			MD.				
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home							
13a. STATE Maryland			13b. COUNTY P.G.			13c. CITY OR TOWN College Park			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 9514 Rhode Island Ave. 20740				
14. FATHER'S NAME FIRST Daniel			MIDDLE I.	LAST Kline	15. MOTHER'S MAIDEN NAME FIRST Sarah			MIDDLE V.	LAST Rohrer	ADDRESS Address Same as No # 13e.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-28-2023			17. INFORMANT Mrs. Mary Lou Dunn						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Reactive</i>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/29 , 19 84 , to 8/31 , 19 84 , that (I) (we) last saw the deceased alive on 8/31 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Abdul Wahed, MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/1/84							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Abdul Wahed, MD			22e. ADDRESS 1600 Oak Hill Ave. HAG. MD 21740													
23a. BURIAL, CREMATION, REMOVAL (SPEC#)			23b. DATE Burial Sept. 4, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood			COUNTY P.G.		STATE Maryland		
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland			25a. DATE REC'D. BY REGISTRAR Sept. 4, 1984			25b. REGISTRAR'S SIGNATURE <i>Julia K. Johnson</i>										

notchless

• 2.0

bivalve

one m0

shallow

leftmost valve notched

concentric

0.702 mm. shell about 1172

2 mm. shell

lenticular

scallops

shells

oval

lenticular

30 concentric

shells

mm. no. 1 var.

concentric

o

x

B

1 mm. 1.0 mm. width of shell 1.31 height of shell

length of shell 1.0 width of shell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23075									
										REG. NO.									
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
		Thelma				I.		Eichelberger				8-17-84					12:15 PM		
3. SEX		F		4. RACE		Caucasian		5. DATE OF BIRTH		MONTH 5 - 23 - 06		6. AGE (IN YEARS LAST BIRTHDAY)		78		IF UNDER 1 YEAR		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		Maryland		7b. CITIZEN OF WHAT COUNTRY?		U.S.A.		8. MARRIED		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Washington		MONTHS		DAYS	
10. CITY OR TOWN OF DEATH		Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		339 N. Cannon Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		Home		HOURS		MIN.	
13a. STATE		Maryland		13b. COUNTY		Washington		13c. CITY OR TOWN		Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		339 N. Cannon Avenue		21748	
14. FATHER'S NAME		Charles		MIDDLE		Vernon		LAST		15. MOTHER'S MAIDEN NAME		Lucy		FIRST		MIDDLE		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		No		16b. SOCIAL SECURITY NO.		214-09-9410B		17. INFORMANT		Arthur L. Eichelberger		same as #13		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										Cancer of breast with widespread bony metastasis									
IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF (b)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 19, 1979, to Aug 17, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug 9, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.																			
22b. SIGNATURE Richard E. Smith, M.D.			DEGREE							22c. DATE SIGNED 8/17/84									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Smith, M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							22e. ADDRESS 1708 Oak Hill Ave, Hagerstown, Md. 21740									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-20-84			23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Hagerstown		COUNTY Wash.		STATE Md.						
24. FUNERAL DIRECTOR NAME Gerald N. Minnich			305 N. Potomac St. Hagerstown, Maryland			25a. DATE REC'D. BY REGISTRAR AUG 22 1984			25b. REGISTRAR'S SIGNATURE Lea Swanson-Randall										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23010				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
John A Everitt						8	23	84	8	23	84	605				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
MALE			White			MONTH	DAY	YEAR	89			IF UNDER 1 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.				
Maryland			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington Co.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Washington Co. Hospital									Cabinet Maker			Lumber Co.	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			MD. 21795			
Maryland			Washington		Williamsport		Route # 3 Box 41									
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT				
William Amos Everitt						Ida Mae Armstrong			214-10-4196			Esther L. Everitt				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			16c. ADDRESS			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Yes WW I			214-10-4196			Route # 3 Box 41			Williamsport, Md. 21795			< 5 min				
18. CAUSE OF DEATH (Enter only one cause per line for item 1b, and 1c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Myocardial infarction</u> < 20 min? { DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b. <u>Pneumonia + cachexia</u>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) <input checked="" type="checkbox"/> this hospital attended the deceased from <u>21</u> 19 <u>68</u> , to <u>8/23</u> 19 <u>84</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>8/23</u> 19 <u>84</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.																
22b. SIGNATURE <u>M.F. Byrkit</u>			22c. DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) M.F. Byrkit			22f. ADDRESS Williamsport Md													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-27-84			23c. NAME OF CEMETERY OR CREMATORIAL Little Rose Hill Cemetery			23d. LOCATION Clear Spring, Washington, MD.			23e. DATE REC'D. BY REGISTRAR				
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md.			ADDRESS									25b. REGISTRAR'S SIGNATURE <u>Judie Davidson-Randell</u>				
BP																

中華書局影印

四



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked (I) (we) did not view the body after death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 23077											
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 8/31/84 2b. HOUR M								
1. DECEASED NAME FIRST REESE MIDDLE MIDDLE LAST FOGARTY			5. DATE OF BIRTH MONTH Jan. DAY 15, YEAR 1915			6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
3. SEX Male 4. RACE White			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.		
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Business Mgr.			12b. KIND OF BUSINESS OR INDUSTRY Motel		
13a. STATE Penna. 13b. COUNTY Franklin 13c. CITY OR TOWN Waynesboro						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 23 S. Broad St. 99999		
14. FATHER'S NAME FIRST Joseph MIDDLE MIDDLE LAST Rosenbloom			15. MOTHER'S MAIDEN NAME FIRST Katherine MIDDLE MIDDLE LAST Fogarty								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. WW II 16c. INFORMANT Mrs. Elmore Z. Fogarty 23 S. Broad St.			ADDRESS Waynesboro, Pa. 17268								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure 2 mon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Arterio sclerotic vascular Disease											
19a. DATE OF OPERATION 7/21/84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal Aorta Aneurysm			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C. S. C. M.D.			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. S. C. M.D.			22e. ADDRESS 201 S. Cleveland Ave Hagerstown, Md.								
23a. BURIAL, CREMATION, REMOVAL IS REQUESTED Burial			23b. DATE 9/3/84			23c. NAME OF CEMETERY OR CREMATORIAL St. Andrew Cemetery			23d. LOCATION CITY OR TOWN Waynesboro, Franklin Pa. COUNTY STATE		
24. FUNERAL DIRECTOR ADDRESS Pa. 17268 50 S. Broad St. Waynesboro			25a. DATE REC'D. BY REGISTRAR SEP 7/1984			25b. REGISTRAR'S SIGNATURE John Ballou, Jr.					

the following information will be
of value to you in your
work on the subject.
The following is a list of
books and papers which have
been published on the subject
of the history of the
United States.
The following is a list of
books and papers which have
been published on the subject
of the history of the
United States.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23078	
FOR 1 - STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
Mabel				Nancy GARDEN HOUR	AUGUST		9	1984	2 P M	20			
3. SEX female		4 RACE white		5. DATE OF BIRTH Nov. 22, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 89		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON							
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AVALON Home Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home							
13a. STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Smithsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P.O. Box 275		E. Water St. 21783			
14. FATHER'S NAME FIRST John		MIDDLE W.	LAST Hoffman	15. MOTHER'S MAIDEN NAME FIRST Emma						LAST Rowe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-50-2988		17. INFORMANT Mr. G. William Gardenhour Sr. Smithsburg, Md.		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Congestive heart failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia										7 days	
		DUE TO, OR AS A CONSEQUENCE OF (c) Generalized atherosclerosis										yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
Chronic urinary tract infections.													
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. none 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2) -									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) None		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 6/2/81 19 to 8-9-84 19, that (I) (we) last saw the deceased alive on 8-9-84 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>W. W. Lesh</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-10-84							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William W. Lesh M.D.		22e. ADDRESS 411 Division Ave Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 12, 1984		23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Cemetery		23d. LOCATION CITY OR TOWN Smithsburg, Wash. Md.							
24. FUNERAL DIRECTOR Davis Funeral Home						25a. DATE REC'D. BY REGISTRAR AUG 15 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

H LOG

ED best SS vol status
X A.B.U almost
blanket

PMG estimation
CFS max .0.1 X standard max .6K

PMG estimation
max .0.1 X standard max .6K

PMG estimation max .0.1 X 6600-02-615 on

PMG estimation max .0.1

standard

PMG estimation max .0.1

PMG estimation max .0.1

on

standard

on

standard

standard

standard

standard

standard

standard

PMG estimation max .0.1 X 6600-02-615 on
PMG estimation max .0.1 X 6600-02-615 on

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23019		
												REG. NO.		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST John MIDDLE Wesley GOSSARD			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
						GOSSARD			8-3-84			7:51 P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		
Male			White			8-19-28			61			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Pennsylvania			U.S.A.						Washington					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			Washington County Hospital			Electrician			Janison Deer					
13a. STATE MD			13b. COUNTY Wash.			13c. CITY OR TOWN Smithsburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt. 2, Box 308 21783		
14. FATHER'S NAME FIRST David MIDDLE - LAST Gessard						15. MOTHER'S MAIDEN NAME FIRST Margie MIDDLE - LAST Baker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
yes WW, II			215-14-2816			Mrs. Elaine M. Gessard, Smithsburg, MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Respiratory failure</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>O. A. Gessard</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>8/5/84</i>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Asenal L. Gessard, MD</i>			22f. ADDRESS <i>1600 Oak Hill Ave. H.A.C. 21740</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Aug. 6, 1984			23c. NAME OF CEMETERY OR CREMATORIUM Smithsburg Cemetery			23d. LOCATION Smithsburg, Wash., MD					
24. FUNERAL DIRECTOR NAME <i>James L. Davis</i> ADDRESS <i>Davis Funeral Home, Smithsburg, MD 21783</i>						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>AUG 15 1984 Julie Davidson-Rendell</i>								

CH 5000 yefasí 300

vofaci

ବିଜ୍ଞାନ

1

...and the following year he was elected to the Senate.

Wastewater treatment plant effluent monitoring program

卷之三

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "No" to any injury, or other traumatic event like medical treatment, then attach a note explaining it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23480			
1 - FOR STATE REGISTRAR				REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR					
Carla				JEAN GREEN	8	9	84			10:50	A.M.				
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
Female		White		Month Day Year June 1 1950		34									
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.							
Virginia		U.S.A.				Washington County		Washington County							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY									
Hagerstown		Washington County Hospital		Blocker		Md. Ribbon									
13a STATE Maryland				13b COUNTY Washington		13c CITY OR TOWN Williamsport		13d INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Rt. 2 Box 133 Williamsport					
										Mary and 21795					
14. FATHER'S NAME FIRST Joseph				MIDDLE Earl		LAST Fisher		15 MOTHER'S MAIDEN NAME FIRST Marjorie		MIDDLE Jean		LAST Biddle			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS							
No				217-56-0545		Charles R. Green Same as 13									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) COMPLETE COLLAPSE LEFT LUNG PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SECONDARY TO METASTATIC CARCINOMA												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EPIDERMOID CA OF VAGINA												3 YEARS			
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE				
22a I certify that (I) (John R. Marsh) attended the deceased from FEB 19 84 to 9 AUGUST 19 84, that (I) (John R. Marsh) saw the deceased alive on 8 AUGUST 19 84, and that in (my) (John R. Marsh) opinion death occurred on the date and hour and from the causes stated above, (I) (John R. Marsh) did not view the body after death.												22c DATE SIGNED 8/9/84			
22b. SIGNATURE John R. Marsh, M.D.												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) John R. MARSH, M.D.												22e. ADDRESS 239 N. POTOMAC ST HAGERSTOWN, MD. 21740			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 8-13-84		23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Mem. Pk.			23d. LOCATION CITY OR TOWN Williamsport		COUNTY Wash. Md.		STATE			
24. FUNERAL DIRECTOR NAME Gerald N. Minnich			305 N. Potomac St. Hagerstown, Maryland					25a. DATE REC'D. BY REGISTRAR AUG 16 1984		25b. REGISTRAR'S SIGNATURE John R. Marsh - Kendall					

Carlo Leon Cesar

11/20/1960 Name & Date



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

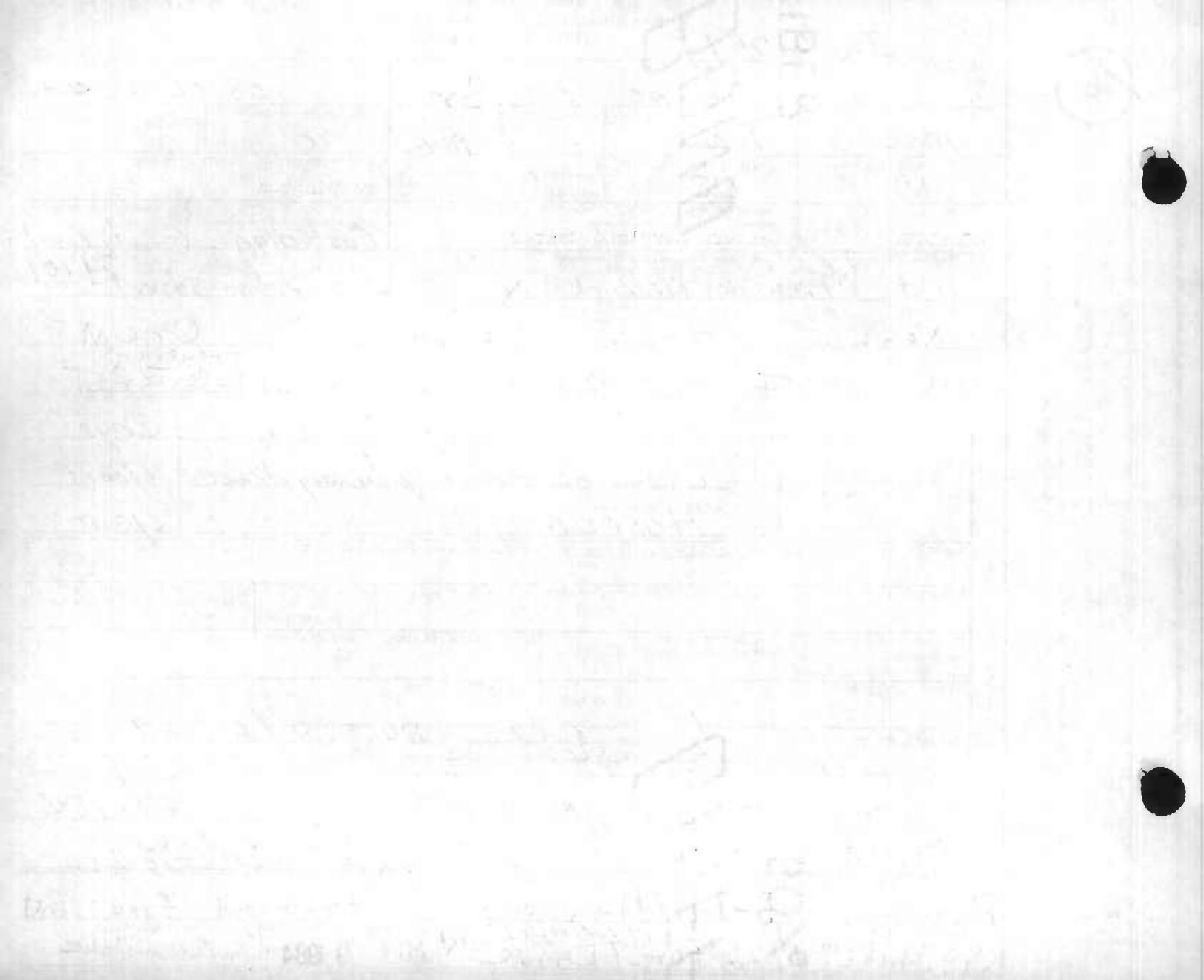
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

B

IMPORTANT: If item 21 is marked as showing any injury, or other traumatic event to medical examiner, please be notified of the notification period.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												2300			
1 - STATE REGISTRAR			Zip 21701									REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH			MONTH	DAY	YEAR	26. HOUR			
James Thomas Hall, Sr						08 06 84						3:30 AM			
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			Black		01 02 1914			70			MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
MD			US						Washington						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
HAGERSTOWN			Western Maryland Center									Custodian			
13a. STATE			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			12b. KIND OF BUSINESS OR INDUSTRY				
MD			Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			217 Center Street 21701			County Court				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST						
			Neel		HALL	Leanna			Ore M						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS						
Yes			WVII 219-05-2915			Adelaide Hall			Frederick 217-Center St						
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Arute Respiratory Failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Days			
(b)			Chronic obstructive pulmonary disease									Years			
(c)			HASCVD									Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/1/1984 to 8/6/1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/6/1984, and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> view the body after death.															
22b. SIGNATURE			DEGREE									22c. DATE SIGNED			
KYUNG S. KIM			M.D.									8/6/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>						
KYUNG S. KIM															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. STAFF			
Burial			8-8-1984			Fairview			Frederick			Fred md			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
C.F. HICKS III			1922 Forest Drive			AUG 9 1984			Lisa Davidson-Randall						
1650 Pennsylvania Ave Hagerstown Md. 21740															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

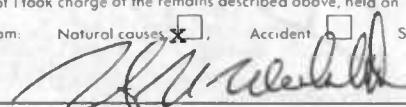
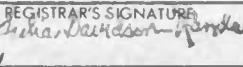
MEDICAL CERTIFICATION

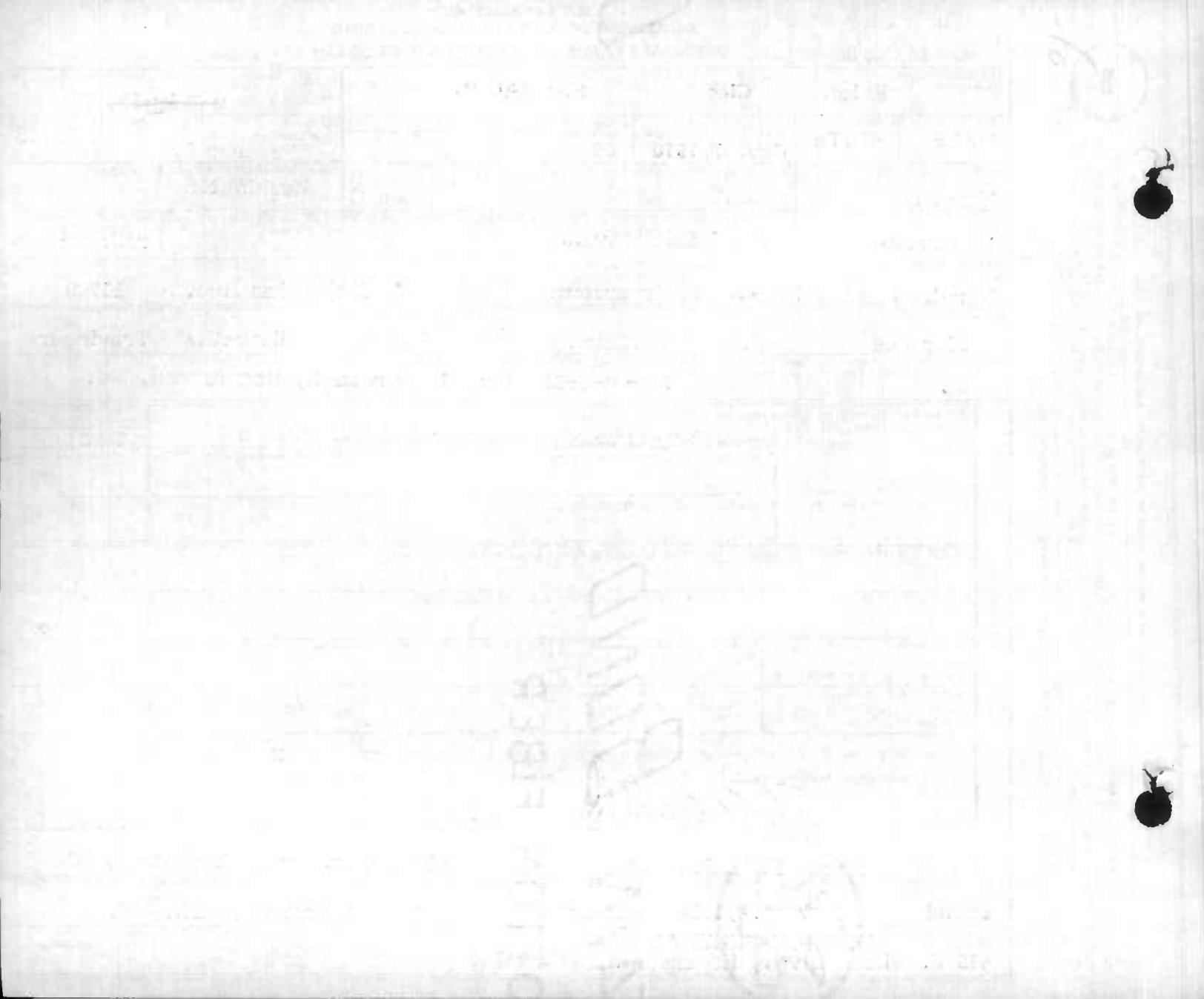
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23 3 3 8 2	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
FRANK			Roger		HAMBY	8 - 26 - 84			12 A.M.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
male		white		Dec. 9, 1909			74		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Pennsylvania		USA					Washington						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Hagerstown		Washington County Hospital		production			aircraft mfg.						
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Maryland		Washington		Hagerstown			520 W. Church St. 21740						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
		Harry		Hamby	Susie								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS						
No		214-09-4913		Dorothy Hamby, Hagerstown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> DID (DID NOT) AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>DR. ROGER HAMBY</i>		22c. DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22d. DATE SIGNED <i>8/27/84</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
ABOVE WALTERED UP		1600 OAK HILL AVE. HAG. MD 21740											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____						
burial		Aug. 29, 1984		Rest Haven Cemetery			Hagerstown, Wash., Maryland						
24. FUNERAL DIRECTOR NAME: MINNICH FUNERAL HOME ADDRESS: 415 E. Wilson Blvd., Hagerstown, Md. 21740												AUG 30 1984	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

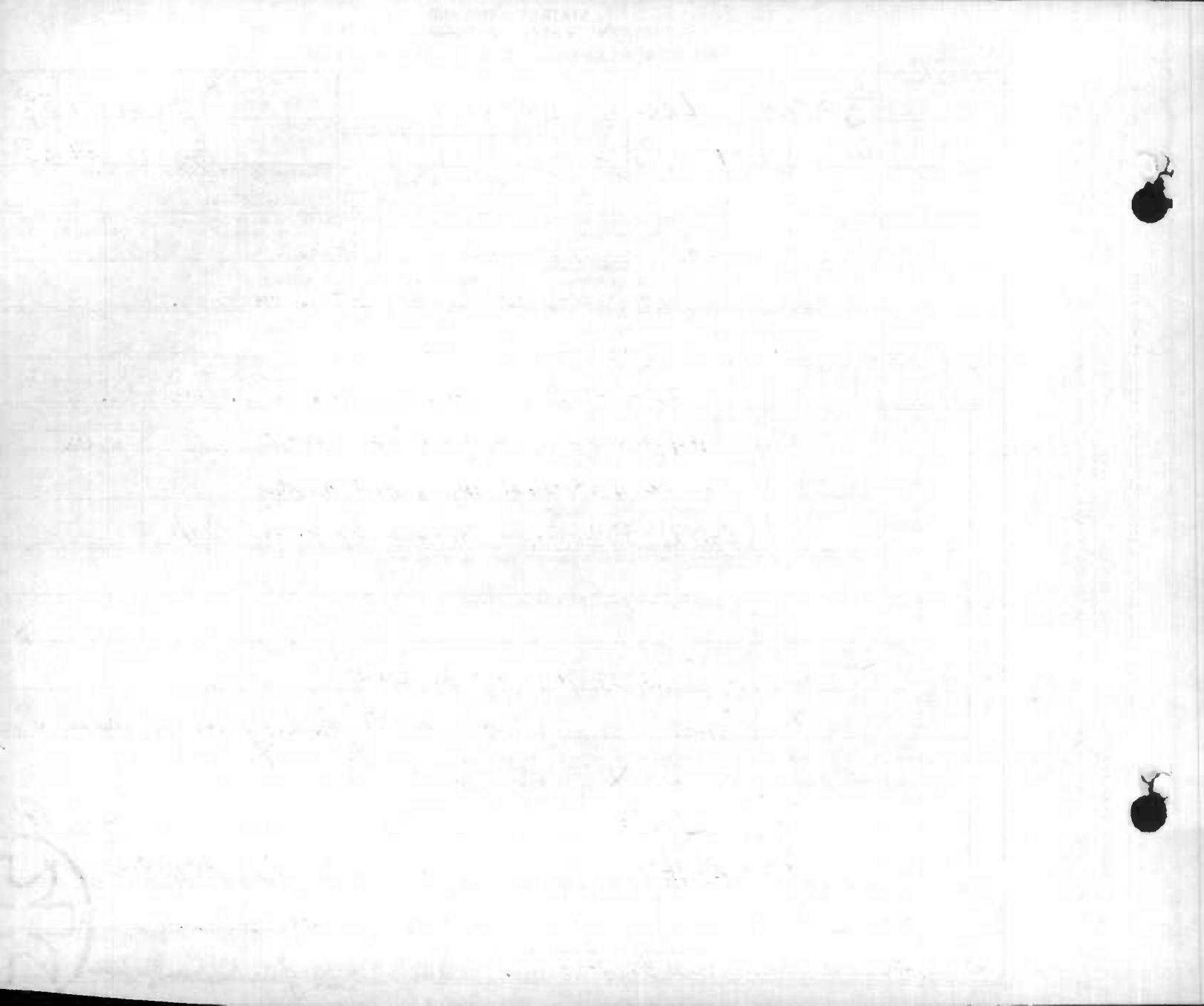
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 23085				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED				
Ralph			Cleo						HARBAUGH			July 31, 84				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS.		2b. HOUR MONTH DAY YEAR				
MALE		WHITE		Feb. 7, 1918		66		MONTHS DAYS		HOURS MIN.		12d. HOUR MONTH DAY YEAR				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington							
Maryland			USA													
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 504 1/2 Salem Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY railroad							
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 504 1/2 Salem Ave. 21740				
14. FATHER'S NAME FIRST Clarence			MIDDLE F.			LAST Harbaugh			15. MOTHER'S MAIDEN NAME FIRST Maude			MIDDLE Elizabeth			LAST Trovinger	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			16c. ADDRESS			17. INFORMANT Donald Harbaugh, Hagerstown, Md.							
No			214-09-6933												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 402-Hypertensive Arteriosclerotic Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE  TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D. ADDRESS 580 Northern Ave., Hagerstown, Md.																
23a. BURIAL, CREMATION, REMOVAL SPECIFY burial			23b. DATE Aug. 4, 1984			23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Md.							
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			25a. DATE REC'D. BY REGISTRAR AUG 9 1984			25b. REGISTRAR'S SIGNATURE 										



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 3 0 8 4																			
1- STATE REGISTRAR																															
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED			MONTH	DAY	YEAR	2b. HOUR													
JASON Lee HARMISON												<input checked="" type="checkbox"/>			Aug 29 1984	5:55	M	2d. HOUR													
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			MONTH		DAY		YEAR												
M		W		Feb 15 75		9 yrs.		MONTHS DAYS		HOURS MIN		Aug 29 1984			5:55		M		2d. HOUR												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. DATE OF BIRTH MONTH DAY YEAR		7d. AGE (IN YEARS LAST BIRTHDAY)		7e. IF UNDER 1 YR.		7f. IF UNDER 24 HRS.		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
WV		USA										Washington County			Hagerstown		Washington County Hospital		Student			MD.									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS		14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS										
WV		Morgan		Berkeley Springs		<input checked="" type="checkbox"/>		307 S. Mercer St.		Harlan E. Harmison II		Susan Harmison		Berkeley Springs 25411		233-25-1892		Susan Harmison, 307 S. Mercer St. WV		Harmison											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypotension and cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Intra abdominal injury and bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (E814) Pedestrian struck by motor vehicle																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)																		21e. LOCATION STREET Johnson Mill Rd		CITY OR TOWN Berkeley Springs		COUNTY Morgan		STATE WV	
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		4 P.M. Aug 29 1984		21g. TITLE (SPECIFY) M.D. Dop		21h. EXAMINER'S NAME H.N. Weeks																		21i. DATE SIGNED Aug 29 84							
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>																		and in my opinion											
ACTUAL SIGNATURE <u>H.N. Weeks</u>		EXAMINER'S NAME H.N. Weeks																		ADDRESS 580 Northern Av Hagerstown Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE																					
Burial		9/1/84		Spring Mills Cemetery		Martinsburg Berkeley WV																									
24. FUNERAL DIRECTOR NAME		ADDRESS		Berkeley Springs, WV		AUG 31 1984		Julie Davidson Pendell																							
Helsley-Johnson Funeral Home		306 Union St.																													



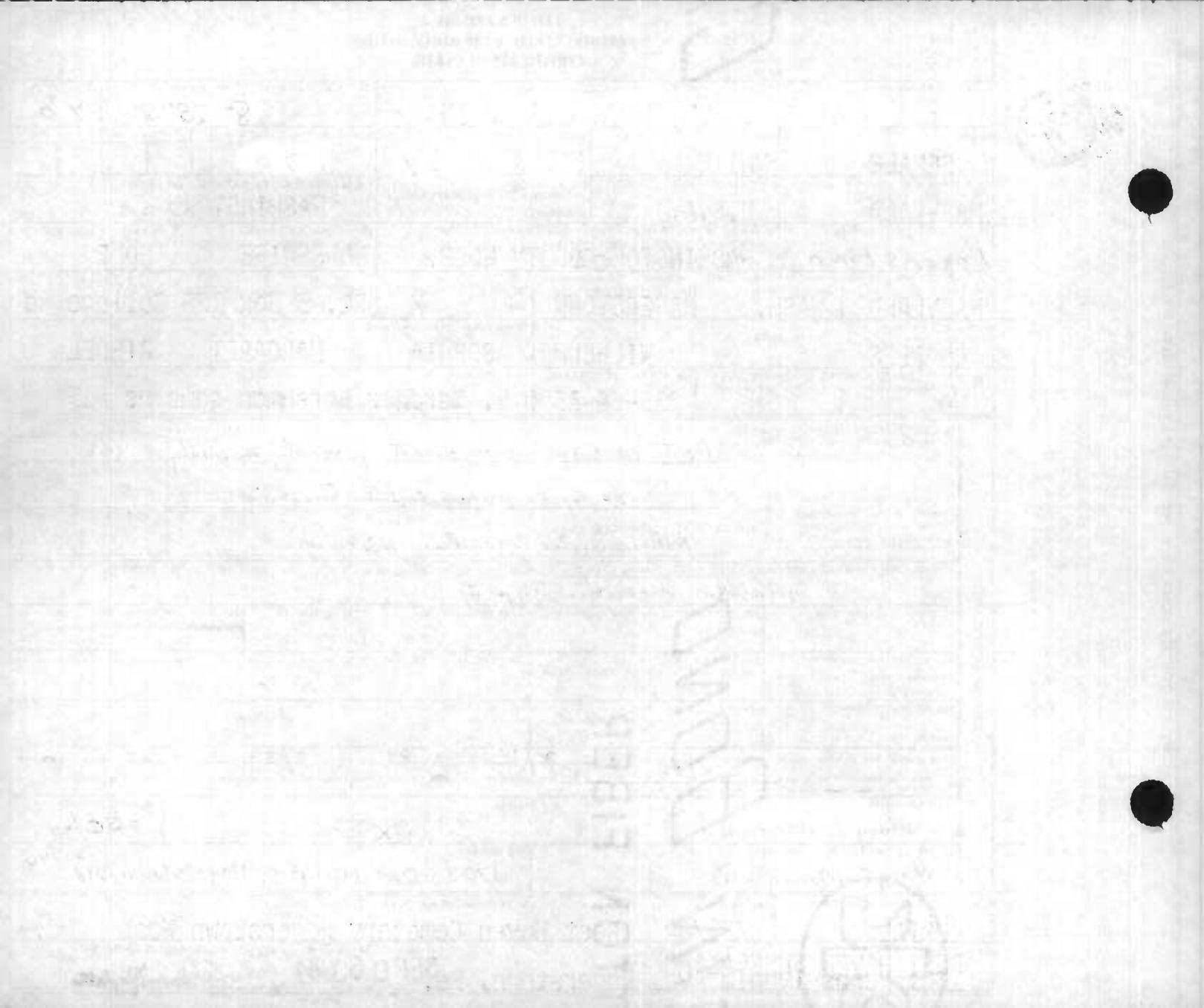
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										2308			
1 - FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
PHYLLIS ELIZABETH HARSHMAN						AUG. 28, 1984						4 P.M.	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
FEMALE			WHITE		MAY 19, 1914			70			# UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.		
MARYLAND			U.S.A.		X NEVER MARRIED <input type="checkbox"/>			WASHINGTON			YRS.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			WASHINGTON COUNTY HOSP.		HOUSEWIFE			HOME			21740		
13a. STATE			13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
MARYLAND			WASH.		HAGERSTOWN			Rt. 3 Box 196 College Rd					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. INFORMANT			ADDRESS	
CHARLES					WILHELM	SOPHIA			Margaret Gardner Harshman same as #13			RIEDEL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			219-66-1590		E. Gardner Harshman same as #13			IMMEDIATE CAUSE (a) Acute cardiopulmonary arrest probably secondary to Acute Myocardial Infarction					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.			DUE TO, OR AS A CONSEQUENCE OF (b) to Acute Myocardial Infarction			DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Vascular Disease.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Diabetes Mellitus, Type II.</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/14 1984 to 8/28 1984, that (I) (we) last saw the deceased alive on 8/28 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <i>Mary E. Money MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/30/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mary E. Money MD</i>			22e. ADDRESS 1708 Oak Hill Ave, Hagerstown, Md.									21740	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/31/84			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown Wash			STATE Md.	
24. FUNERAL DIRECTOR REST HAVEN FUNERAL HOME 1601 Pennsylvania Ave, Hagerstown, Md.									25a. DATE REC'D. BY REGISTRAR SEP 6 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pandell</i>	



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resigned by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23380					
1 - STATE REGISTRAR				REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)		PAUL		R.		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
								HESSON		Aug 20, 1984					205 PM		
3. SEX		MALE		WHITE		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 18 YEARS		IF UNDER 24 HRS			
								MONTH 28 DAY 09		75		MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		MD		U.S.A		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Washington Co. MD.					
10. CITY OR TOWN OF DEATH		Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Washington County Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		Retired - RR		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE		MD		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		1243 Summit Ave. 21740					
14. FATHER'S NAME		FIRST JACOB	MIDDLE H	LAST HESSON		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
								NO		219-12-2019		Harry Hesson		1744 Burnside Ave Hagerstown, Md. 21740			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) CIRCULATORY COLLAPSE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		DUE TO, OR AS A CONSEQUENCE OF MULTIPLE ORGAN FAILURE															
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)															
		DUE TO, OR AS A CONSEQUENCE OF Post op Hepatic Failure (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Bone marrow suppression, GI bleeding																	
19a. DATE OF OPERATION 7/16/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal aortic aneurysm		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE S. R. Boikar		22c. DEGREE MD		22d. ATTENDING PHYSICIAN MD		22e. MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED									
22f. PHYSICIAN'S NAME (TYPE OR PRINT) S. R. Boikar		22g. ADDRESS WASH COUNTY Hosp															
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 8/23/84		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cem.		23d. LOCATION CITY OR TOWN Hagerstown, Wash. Md.											
24. FUNERAL DIRECTOR NAME REST HAVEN FUNERAL HOME		ADDRESS 1601 Pennsylvania Ave. Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR AUG 23 1984		25b. REGISTRAR'S SIGNATURE Julia L. Boikar											
DHMH - 16 50M 4/83 (VRA 15, 4)																	

A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return it to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician should be consulted before signing this certificate.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23087																														
												REG. NO.																														
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR																						
			Frederick W									Higgins			08 24 84				8:30	P.M.																						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
M			White			MONTH DAY YEAR			57			USA			<input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington Co.		Hagerstown			Washington Co. Hospital			13a. STATE		13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
MD						10 05 26														RT 2 Box 355					Harry Higgins			Olive Mae Chaney														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			16c. INFORMANT			17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Debrue Histocytte Lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																														
yes			1952			217281299			Arleen E. Higgins see #13																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED P.M.		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)		21e. LOCATION STREET		21f. CITY OR TOWN		21g. COUNTY		21h. STATE																												
21i. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		19						8/24/84		8/24/84		8/24		8/24																												
22a. I certify that (I) (this hospital) attended the deceased from <u>8/24/84</u> to <u>8/24/84</u> , that (I) (we) last saw the deceased alive on <u>8/24/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE <u>Frederick W. Higgins III</u>		22c. DEGREE <u>M.D.</u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>8/25/84</u>																								
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS <u>1825 Howell Rd Hagerstown Md</u>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>8-27-84</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Blairs Valley Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Blairs</u>		23e. COUNTY <u>Elkley Co., Md.</u>																														
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR <u>AUG 27 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Hudson Pendell</u>																																						
Gerald N. Minich																																										

578

A24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or age.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23085		
												REG. NO.		
1 - STATE REGISTRAR			1. DECEDENT NAME (TYPE IN PENCIL)			FIRST MIDDLE LAST			2a DATE OF DEATH / MONTH DAY YEAR			2b HOUR		
			Bertha Dorcas Houck						August 11, 1984			1:20a.m.		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		
Female			White			June 12, 1924			60			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
Ohio			U.S.A.									Washington		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			Washington County Hospital			Nurse			Pangborn					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE MD			13b. COUNTY Wash.			13c. CITY OR TOWN Smithsburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt. 2, Box 314 21783		
14. FATHER'S NAME FIRST John			MIDDLE E.			LAST Lewis			15. MOTHER'S MAIDEN NAME FIRST Sarah			LAST Wellings		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a))												18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a))		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												18b. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (b))		
18c. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (c))												18d. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (d))		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Mr. J. William Houck, Smithsburg, MD 21783</i>												18e. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (e))		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY			20b. IF YES, WERE FINDINGS USED IN DETERMINING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20c. IF YES, WERE FINDINGS USED IN DETERMINING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) this hospital attended the deceased from <i>8-10-84</i> , 19 <i>60</i> , to <i>8-11-84</i> , 19 <i>60</i> , that (II) (we) last saw the deceased alive on <i>8-10-84</i> , 19 <i>60</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												22b. DATE SIGNED <i>8-11-84</i>		
22c. SIGNATURE <i>F. R. Rodriguez</i>			22d. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22e. PHYSICIAN'S NAME, TITLE OR SPN <i>F. R. Rodriguez</i>			22f. ADDRESS <i>382 South Cleveland, Hagerstown</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 14, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., MD			23e. DATE REC'D. BY REGISTRAR		
24. FUNERAL DIRECTOR NAME <i>David Funeral Home, Smithsburg, MD 21783</i>												25b. REGISTRAR'S SIGNATURE <i>Judy Davidson-Rendell</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23087	
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR August 24, 1984							2b. HOUR 9:50 AM	
1. DECEASED NAME FIRST Ollie MIDDLE Mae LAST HUFFMAN			5. DATE OF BIRTH MONTH July DAY 18, 1891 YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
3. SEX female		4. RACE white		7. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Coffman Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk			12b. KIND OF BUSINESS OR INDUSTRY dept. store		
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 3 21713		
14. FATHER'S NAME FIRST John MIDDLE M. LAST Miller			15. MOTHER'S MAIDEN NAME FIRST Emma MIDDLE B. LAST Wood								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO (If yes, give war or dates)			16b. SOCIAL SECURITY NO. 219-20-3104			17. INFORMANT Kathleen H. Jones, Lancaster, Pa.			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RECENT CEREBRAL VASCULAR ACCIDENT { DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										5½ MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). GANGRENE OF TOES											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <input checked="" type="checkbox"/> hospital attended the deceased from MARCH 9, 1984, to AUGUST 24, 1984, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on JUNE 26, 1984, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If we <input checked="" type="checkbox"/> did not) view the body after death.										22c. DATE SIGNED AUG. 24, 1984	
22b. SIGNATURE Edward W. Ditto, M.D.										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.			22e. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740								
23a. BURIAL, CREMATION, REMOVAL <small>(SPECIFY)</small> burial			23b. DATE Aug. 27, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery			23d. LOCATION CITY OR TOWN Boonsboro, Wash., Maryland COUNTY STATE		
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740										25a. DATE REC'D. BY REGISTRAR AUG 30 1984 25b. REGISTRAR'S SIGNATURE Julie Davidson, Registar	

• Y СОЮЗНЫХ РАДИОАВИАЦИОННЫХ ОБОРОННОСТРЕЛЯ
HTI

СИГНАЛ РАДИОСАЙЛАНДИИ ТЕЛЕ

СВОЙ СИГНАЛ

Х Х САМОУДАРЫ Х Х
Х Х САМОУДАРЫ Х Х

САМОУДАРЫ

САМОУДАРЫ ТЕЛЕ
САМОУДАРЫ САМОУДАРЫ

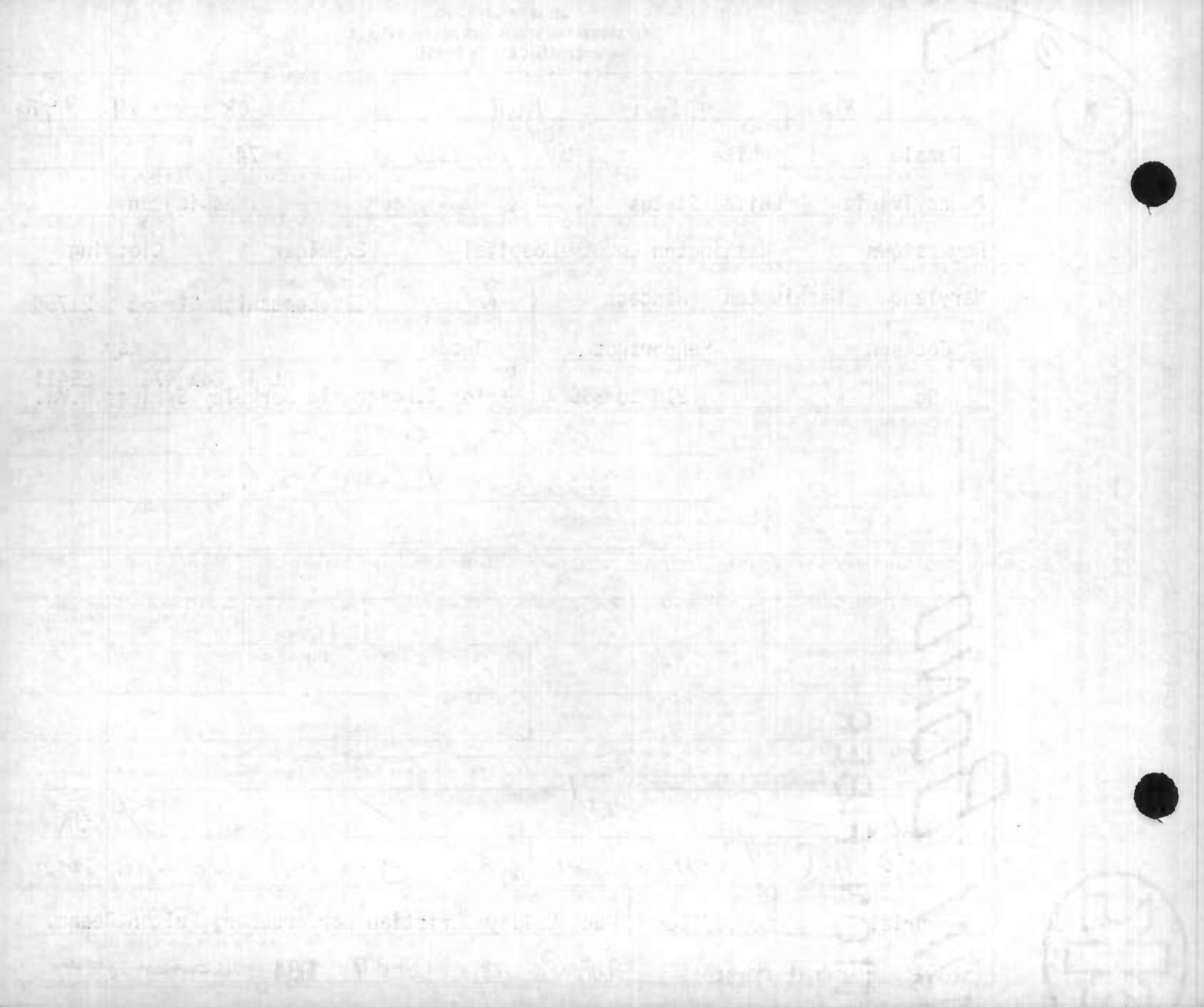
САМОУДАРЫ САМОУДАРЫ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23090		
1 - FOR STATE REGISTRAR			REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Mary Ellen Hull						08 • 30 • 84						9:00 pm		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female			White			MONTH DAY YEAR May 26, 1910			74 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Pennsylvania			United States						Washington					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			Washington County Hospital			Examiner			Clothing					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland			Washington		Hancock					112 West High Street 21750				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Jackson					Hendershot	Rhoda								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
No			218 30 8558A			Marion I. Hovermale			Rt 4 Box 471 25411 Berkeley Springs, W.Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) DUE TO, OR AS A CONSEQUENCE OF Cystic fibrosis														
(c) DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS									18/8/84		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE		
Burial			09/02/1984			Buck Valley Christian			Warfordsburg, Fulton, Penna.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Groves Funeral Home			Hancock Md			SEP 7 1984			Julia Davidson-Randall					



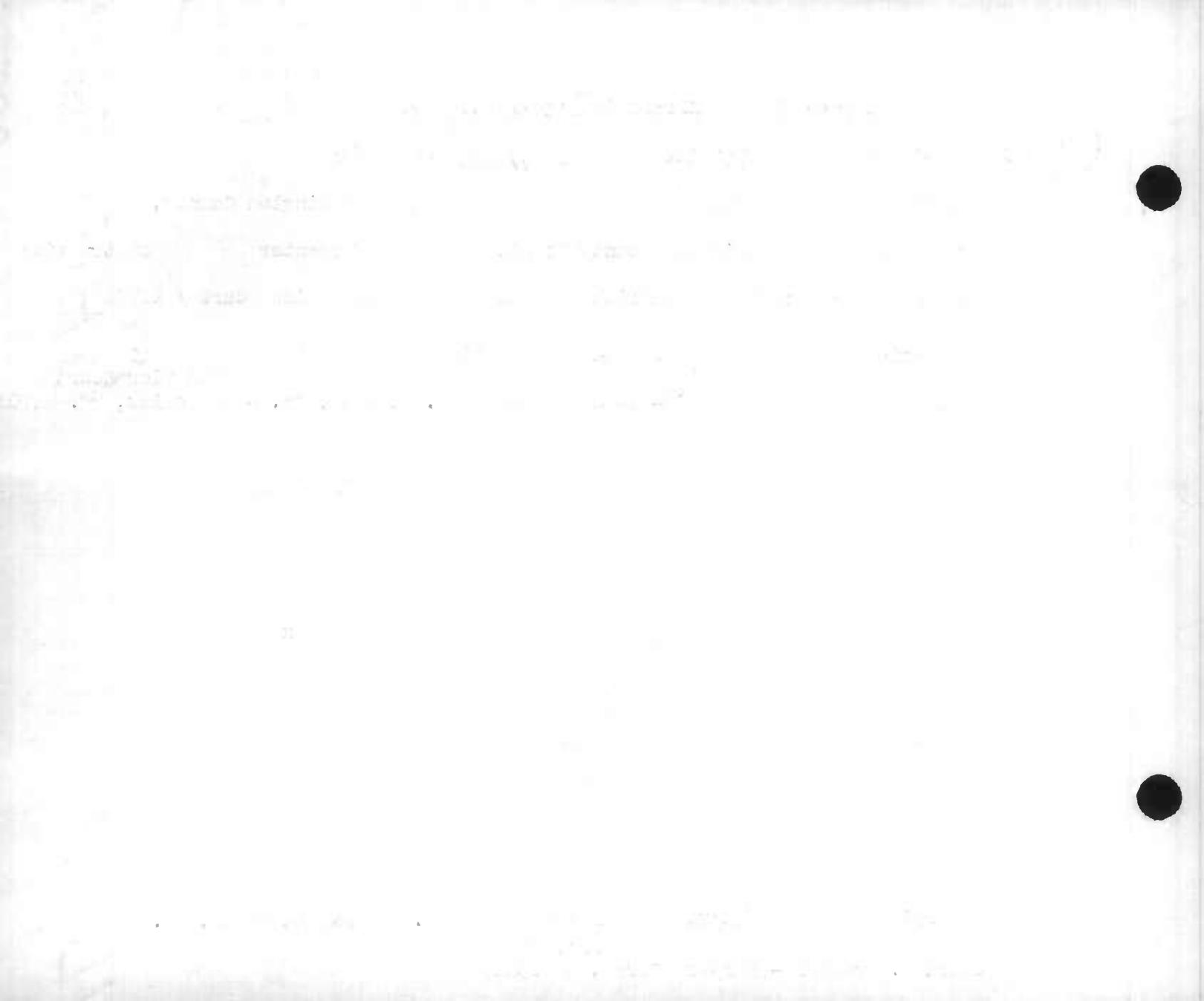
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-tranport permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 showed any injury, or other traumatic event, the medical examiner may be notified before the death certificate is filed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 23091	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR 8-15-84	2b. HOUR 12 PM
ARTHUR Franklin Johnson, Sr.							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR 12-16-1907		6. AGE (IN YEARS LAST BIRTHDAY) 76	
Male		White				IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9304 View Court / 21701	
14. FATHER'S NAME FIRST Daniel		MIDDLE ?	LAST Johnson	15. MOTHER'S MAIDEN NAME FIRST Viola		MIDDLE ?	LAST ?
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 232-01-0200		17. INFORMANT Arthur F. Johnson, Jr. - Frederick, Md. 21701		ADDRESS 9304 View Court APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Q. L. Spencer</i>		DEGREE				22c. DATE SIGNED 8/15/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Abdul Wahed, M		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22e. ADDRESS 1600 Oak Hill Ave. Hagerstown, Md. 21740	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/18/84		23c. NAME OF CEMETERY OR CREMATORIAL Samples Manor Cem.		23d. LOCATION CITY OR TOWN Samples Manor, Md.	
24. FUNERAL DIRECTOR NAME Robert L. Spencer - Harpers Ferry, WV 25425		25a. ADDRESS Drawer C		25b. DATE REC'D. BY REGISTRAR AUG 23 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be initialed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(REPORTANT: If Item 21 is minor, enter 01 in Part 18 showing any injury, or other traumatic event, the medical examiner must be informed.)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23092					
										REG. NO.					
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
			MARY E Jones						8-21-84					5:25 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH	
F		W		MONTH DAY YEAR 12-22-1892			91		U. S. A.					Washington	
YRS.				MONTHS DAYS		HOURS MIN.								MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington County Hospital							Housewife			Own Home		
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rfd. 3 Box 267 21713					
14. FATHER'S NAME John			MIDDLE LAST Long			15. MOTHER'S MAIDEN NAME Martha			MIDDLE Miller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218- 38-1931			17. INFORMANT Ralph L. Jones, Rfd. 3 Box 267 Boonsboro, Md. 21713			ADDRESS						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral pneumonia.			DUE TO, OR AS A CONSEQUENCE OF (c) Congestive heart failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>John L. Lee</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/21/84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Abdul WATSON MD</i>			22e. ADDRESS 1600 Oak Hill Ave. Hagerstown												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-23-84			23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery			23d. LOCATION CITY OR TOWN Boonsboro, Wash. Co., Md.			STATE			
24. FUNERAL DIRECTOR John H. Bast, Jr. Boonsboro, Md. 21713			ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG 23 1984			25b. REGISTRAR'S SIGNATURE <i>Jeanne Dawson-Bast</i>			i			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certifcate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certifcate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item B above any injury, or other traumatic event, the medical examiner shall be notiifed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23093					
												REG. NO.					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			8 28 84	7 48 AM				
SAMUEL NEWMAN KAUFMAN																	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
MALE			CAUC			MONTH DAY YEAR			69			MONTHS	DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			YRS			IF UNDER 24 HRS					
New York			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			HOURS			MONTHS					
9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN THIS FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE)			12b. TRADE, BUSINESS OR INDUSTRY					
Washington Co.			Hagerstown			Washington Co. Hospital			salesman			swimming pools					
13a. STATE			13b. COUNTY			CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Md.			Wash.			Hagerstown						21740 Harbinger Circle					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME PAULINE			MIDDLE					
JACOB						KAUFMAN						OGALITZER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS 21740					
No			080-12-3637			Eleanor Kaufman			Hagerstown, Md.								
									Cardiopulmonary arrest								
									DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardiovascular disease								
									DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED P.M. 19			(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (his/her) attended the deceased from 5/12/77 to 8/28/84, that (I) (he) last saw the deceased alive on 6/25/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (he) did not view the body after death.																	
22b. SIGNATURE			22c. DEGREE			22d. DATE SIGNED											
George Newman II Ph.D. M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									8/28/84					
22e. ADDRESS																	
George Newman II												Hagerstown, Md. 21740					
23a. BURIAL, CREMATION, REMOVAL SPECIFY			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial			Aug. 29, 1984			Resthaven Mem. Gard. Frederick Fred. Md.			21769								
24. FUNERAL DIRECTOR NAME									25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Thompson Funeral Home Middletown, Md.												SEP 04 1984		John Gardner Pendleton			

George Mann II

8/28/83

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23094					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
FRANCES ERMA KEMP										8/6/84				10:50 AM	
3. SEX		4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)							
Female		White			9 24 1899			84							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
West Virginia		U.S.A.						Washington							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Western Maryland Center						Clerk			Retail Dept.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										31740					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE							
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1741 Edgewood Hills							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
Daniel		Mc Clain		Kemp		Laura		Virginia		Wolfe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ADDRESS Williamsport, Maryland				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months		
No		214-09-0641			Edwin M. Kemp 2J Milestone Garden Apt.		Congestive Heart Failure								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		Hyper-tension Heart Disease								years			
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY		20b. IF, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
19c. MEDICAL CERTIFICATION															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from the deceased alive on 8/6 1984 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I <input checked="" type="checkbox"/> did <input type="checkbox"/> not) view the body after death.					3/16 1982 to 8/6 1984										
22b. SIGNATURE ROSE MARIE CHAN M.D.					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		DATE SIGNED 8/6/84				
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		ROSE MARIE CHAN			22e. ADDRESS Western Maryland Center, Hagerstown										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		Maryland				
Burial		8-8-84		Rest Haven Cemetery			Hagerstown		Wash. Md.		31740				
24. FUNERAL DIRECTOR NAME		305 N. Potomac St.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Gerald N. Minnich		Hagerstown, Maryland			AUG 9 1984										

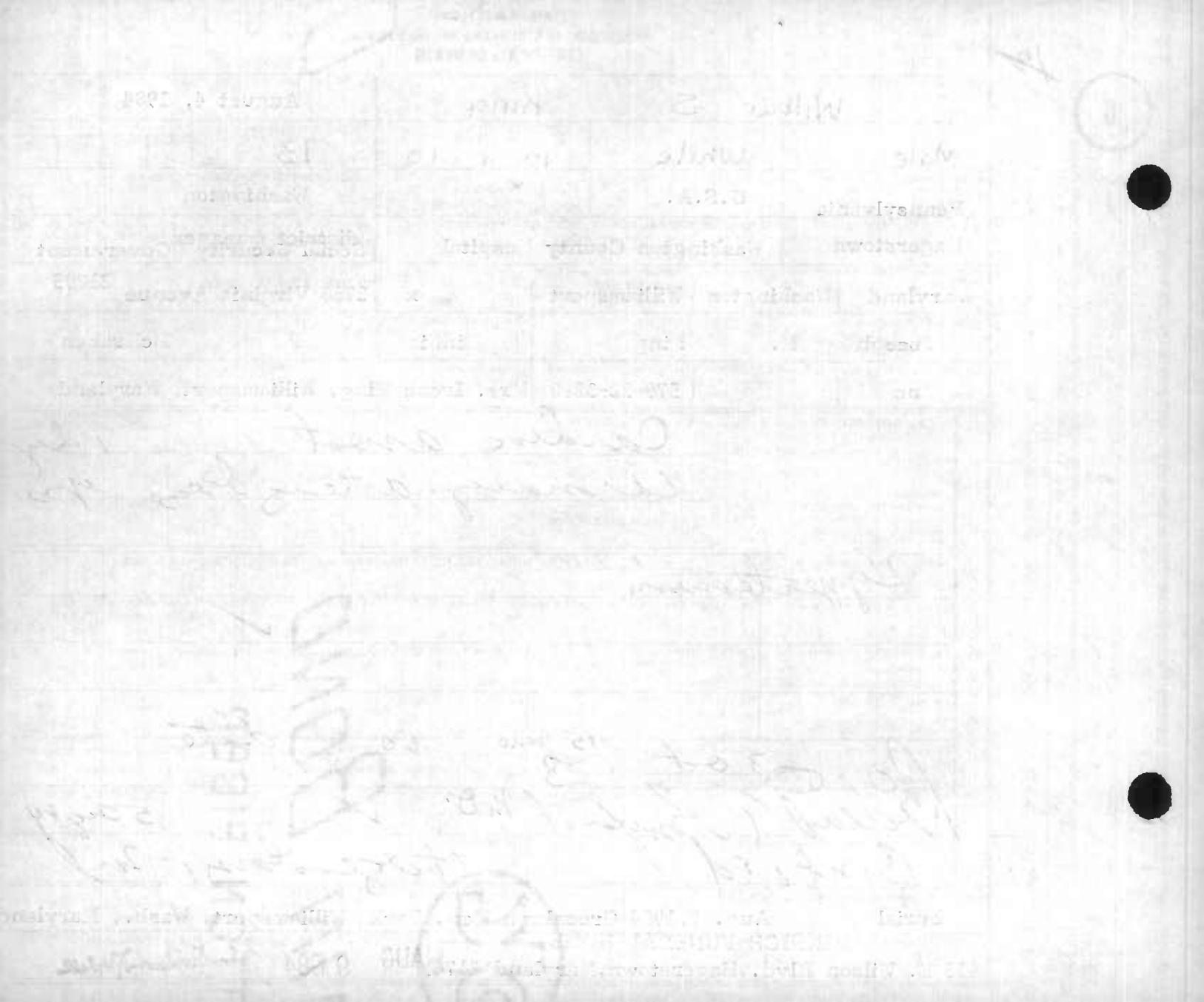
1042A 00093

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page one

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use at the burial facility. Then please remove all papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 26 shows any injury, air other traumatic event, the medical certifier must be notified or once

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23095											
												REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR									
Wilbur S King							August 4, 1984							M									
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS										
Male		White		MONTH	DAY	YEAR	73				MONTHS	DAYS	HOURS	MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.			9. BALTIMORE CITY OR COUNTY OF DEATH																
Pennsylvania		U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington																
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY									
Hagerstown		Washington County Hospital										district manager Social Security		Government									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21795	
												Maryland		Washington		Williamsport		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2750 Virginia Avenue			
14. FATHER'S NAME				FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME				FIRST	MIDDLE	LAST	McKraken									
Joseph M. King							Minnie																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
no				579-22-3290				Mrs. Irene King, Williamsport, Maryland															
18. CAUSE OF DEATH (Enter only one cause per line for items 18, 19, and 20) PART I. DEATH WAS CAUSED BY												IMMEDIATE CAUSE (a)				19. DECEASED BETWEEN CERTAIN DATES							
												Cardiac arrest				1 day							
												DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease				20. DECEASED BETWEEN CERTAIN DATES							
												Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last				21. DECEASED BETWEEN CERTAIN DATES							
												DUE TO, OR AS A CONSEQUENCE OF (c)				22. DECEASED BETWEEN CERTAIN DATES							
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												Hyperension											
24. MEDICAL CERTIFICATION				25a. DATE OF OPERATION				25b. CONDITION FOR WHICH OPERATION WAS PERFORMED				25c. AUTOPSY?		25d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
26a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 26b. EITHER NOTED MEDICAL EXAMINER				26b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				26c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 26 PART 2 OR PART 3)															
27a. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>				27b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				27c. LOCATION STREET				CITY OR TOWN		COUNTY STATE									
28a. I certify that (i) this hospital attended the deceased from <u>15 June 1960</u> to <u>date</u> , that (ii) we last saw the deceased on <u>3 Oct 86</u> at <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if we did not see the body after death).																							
29a. SIGNATURE				30. PHYSICIAN'S NAME (TYPE OR PRINT)				31. DEGREE				32. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		33. THE DATE SIGNED									
Robert J. Binfrey M.D.				Robert J. Binfrey M.D.										5 Aug 84									
34. BURIAL, CREMATION, REMOVAL burial				35a. DATE				35c. NAME OF CEMETERY OR CREMATORIAL				35d. LOCATION CITY OR TOWN		COUNTY STATE									
burial				Aug. 7, 1984				Greenlawn Mem. Park				Williamsport, Wash., Maryland											
36. FUNERAL DIRECTOR NAME				ADDRESS				37a. DATE REC'D. BY REGISTRAR				36b. REGISTRAR'S SIGNATURE											
MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740								AUG 9 1984				Julie Davidson-Bender											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23096					
1 - FOR STATE REGISTRAR		REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)		Frances Louise KLINE			Frances L. Kline			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
3. SEX		Female			White			5. DATE OF BIRTH		MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		
										12	08	12	71		
7a. BIRTHPLACE (COUNTRY)		Ohio			U.S.A.			7b. CITIZEN OF WHAT COUNTRY?		MARRIED	NEVER MARRIED	<input type="checkbox"/>	8. IF UNDER 1 YEAR		
										WIDOWED	DIVORCED	<input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH		HAGERSTOWN			WASHINGTON Co. Hospital			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE		Md.			13b. COUNTY		Wash.	13c. CITY OR TOWN		Dietary Dept.			W.C.H.		
14. FATHER'S NAME		FIRST Edward	MIDDLE B.	LAST Blickenstaff				15. MOTHER'S MAIDEN NAME		FIRST Mabel	MIDDLE Susan	LAST Kline			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		220-28-8850	17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cancerous of head of the pancreas</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2005</i>	
										DUE TO, OR AS A CONSEQUENCE OF (b) <i>a Polarity of function</i>					
										DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Hematoxylia</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>8/17/1984</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did (did not) view the body after death.														22c. DATE SIGNED <i>8/20/84</i>	
22b. SIGNATURE <i>Edward B. Blickenstaff</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edward B. Blickenstaff</i>			22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Burial Aug. 21, 1984</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Cavetown Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Cavetown, Wash., MD</i>							
24. FUNERAL DIRECTOR <i>Davis Funeral Home, Smithsburg, MD 21783</i>		25a. DATE RECEIVED BY REGISTRAR <i>AUG 28 1984</i>			25b. REGISTRAR'S SIGNATURE <i>John Harbinson-Pender</i>										

SEARCHED INDEXED SERIALIZED FILED
X A.G.U. OCT 10 1968

H.C. 1968-10-10 1968-10-10

SEARCHED INDEXED SERIALIZED FILED
A.G.U. OCT 10 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with him 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23091									
												REG. NO.									
1 - FOR STATE REGISTRAR			FIRST <u>Minnie</u> <u>Minnie</u>			MIDDLE <u>Myrtle</u> <u>M</u>			LAST <u>LEWIS</u> <u>Lewis</u>			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)												
3. SEX			White			MONTH 3 DAY 21 YEAR 1984			IF UNDER 1 YEAR MONTHS 100		IF UNDER 24 HRS MONTHS YRS										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u>		10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington County Hospital</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Wash.</u>			13c. CITY OR TOWN <u>Cavetown</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>P. O. Box 46</u> <u>21720</u>										
14. FATHER'S NAME FIRST <u>Jacob</u>			MIDDLE -			LAST <u>Hoffman</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Anna</u>		16. ADDRESS <u>Deibert</u>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -			17. INFORMANT <u>Mr. Keller F. Lewis, Cavetown, Maryland</u>			18. CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>long time Heart Failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) <u>Arterio sclerotic Heart Disease</u>			(c) <u>years</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>hypertension</u> <u>dehydration</u>																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 6, 1984</u> , to <u>Aug. 6, 1984</u> , that (I) (we) last saw the deceased alive on <u>Aug. 6, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <u>8/6/84</u>									
22b. SIGNATURE <u>Gloria F. Pura</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GLORIA F. PURA</u>			22e. ADDRESS <u>339 E. Antietam St - Hagerstown</u>																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>Aug. 9, 1984</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Cavetown Cemetery</u>			23d. LOCATION <u>Cavetown, Wash., MD</u>												
24. FUNERAL HOME <u>DANIS Funeral</u>			25a. DATE REC'D. BY REGISTRAR <u>AUG 15 1984</u>			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Purdelle</u>															

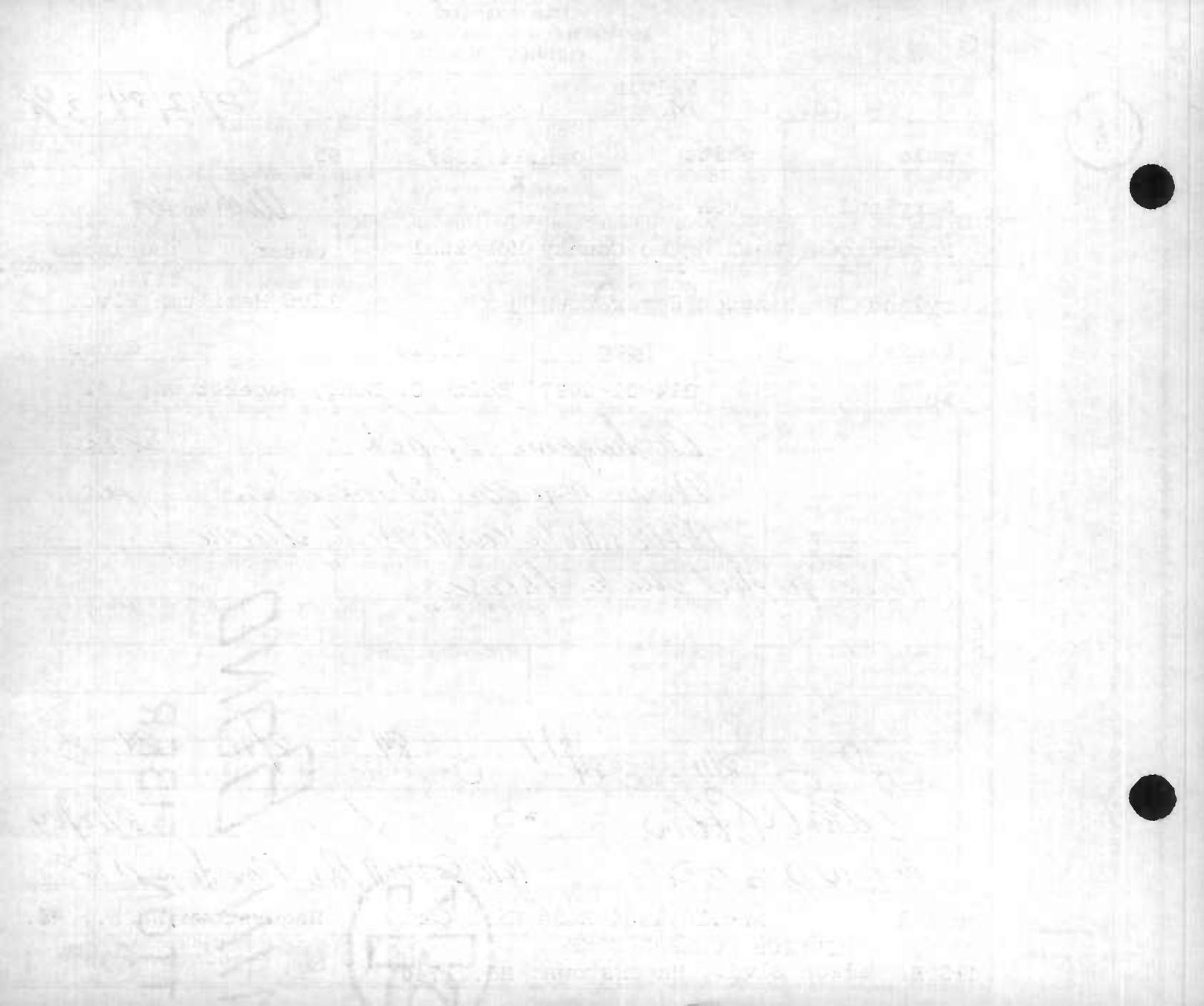
3125 W. Broadway, Suite 100, Lakewood, CO 80401

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please notify the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. It should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23098		
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR <i>8/12/84</i>									REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Albert</i>	MIDDLE <i>M.</i>	LAST <i>Long</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 14, 1889</i>			6. AGE (IN YEARS LAST BIRTHDAY) 95 yrs			2b. HOUR <i>3 PM</i>		
3. SEX male			4. RACE white			7. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i>		
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>owner</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>business equip.</i>					
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Washington</i>			13c. CITY OR TOWN <i>Hagerstown</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>21740</i> <i>1206 Hamilton Blvd.</i>		
14. FATHER'S NAME FIRST <i>Daniel</i>			MIDDLE <i>M.</i>	LAST <i>Long</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Mollie</i>			MIDDLE			LAST <i>Cross</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IE YES, GIVE WAR OR DATES) <i>214-09-0097</i>			17. INFORMANT <i>Edith C. Long, Hagerstown, Md.</i>			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>week</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiogenic shock.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Plaque myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerotic cardiovascular disease</i> years														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Severe peripheral vascular disease.</i>														
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <i>saw the deceased alive on 8/11 1984</i>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>8/11</i>			21f. LOCATION STREET <i>1610 Oak Hill Ave.</i>			CITY OR TOWN <i>Hagerstown</i>	COUNTY <i>Wash.</i>	STATE <i>Md.</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>8/11</i> , 19 <i>84</i> , to <i>8/11</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>8/11</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.														
22b. SIGNATURE <i>Albert W. Dill MD</i>			22c. DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <i>8/12/84</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Albert W. Dill MD</i>			22e. ADDRESS <i>1610 Oak Hill Ave. Hagerstown MD</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>			23b. DATE <i>Aug. 16, 1984</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Rose Hill Cem.</i>			23d. LOCATION CITY OR TOWN <i>Hagerstown</i>			COUNTY <i>Wash., Md.</i>		
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>			25. DATE REC'D. BY REGISTRAR NAME <i>Jeanne Dardouin-Pendell</i>			25. REGISTRAR'S SIGNATURE <i>AUG 15 1984</i>								
ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>														



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use on the burial certificate. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23094					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
RENO			RUODOLPH	LOWE		8-12-84						1:00 P.M.			
3. SEX MALE			4. RACE I White		5. DATE OF BIRTH MONTH 10 DAY 12 YEAR 04			6. AGE (IN YEARS LAST BIRTHDAY) 79			IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON							
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE M.D.			13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1027 View St. 21740				
14. FATHER'S NAME FIRST JOHN MIDDLE Lowe LAST			15. MOTHER'S MAIDEN NAME FIRST MARGARET MIDDLE Belle LAST SHORT			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 219-36-3685			17. INFORMANT SALLY O. LOWE - Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the pancreas DUE TO, OR AS A CONSEQUENCE OF (b) Rheumatoid arthritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (the hospital) attended the deceased from 8-3 1984 to 8-12 1984 , that (I) (was) lost saw the deceased alive on 8-10 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did not see the body after death) .										22c. DATE SIGNED 8-13-84					
22b. SIGNATURE E. Bell		22c. DEGREE MD								ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (IF APPLICABLE)		22e. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 8/13/84		23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.								25a. DATE REC'D. BY REGISTRAR AUG 20 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

12
B
be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23100
										REG. NO.
1 - FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)		FIRST <i>LOUIS</i>	MIDDLE <i>E</i>	LAST <i>LUSHBAUGH</i>	2a DATE OF DEATH MONTH DAY YEAR		2b. HOUR 7:00 AM	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH Dec. 29, 1910 YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Washington		MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) secretary			12b. KIND OF BUSINESS OR INDUSTRY storage & transfer			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 133 Summit Ave. 21740	
14. FATHER'S NAME FIRST William		MIDDLE Leiter		LAST	15. MOTHER'S MAIDEN NAME FIRST Minnie			MIDDLE	LAST Keller	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-10-2526		17. INFORMANT Frank Lushbaugh, Charles Town, W. Va.			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE RESPIRATORY FAILURE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY EMPYSEMA</u>										YEARS 7 YEARS
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) DEHYDRATION, SEVERE										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 71 to AUGUST 16, 1984 , that (we) last saw the deceased alive on AUGUST 15, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 016-84
22b. SIGNATURE <i>Barry M. Cohen</i>		22c. DEGREE <i>MP</i>		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 016-84			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Barry M. Cohen		22f. ADDRESS 339 E ANTETAM ST HAGERSTOWN MD 21740								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Aug. 18, 1984		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Md.		23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR 10/16/84		25b. REGISTRAR'S SIGNATURE <i>John J. Minnich</i>						

A

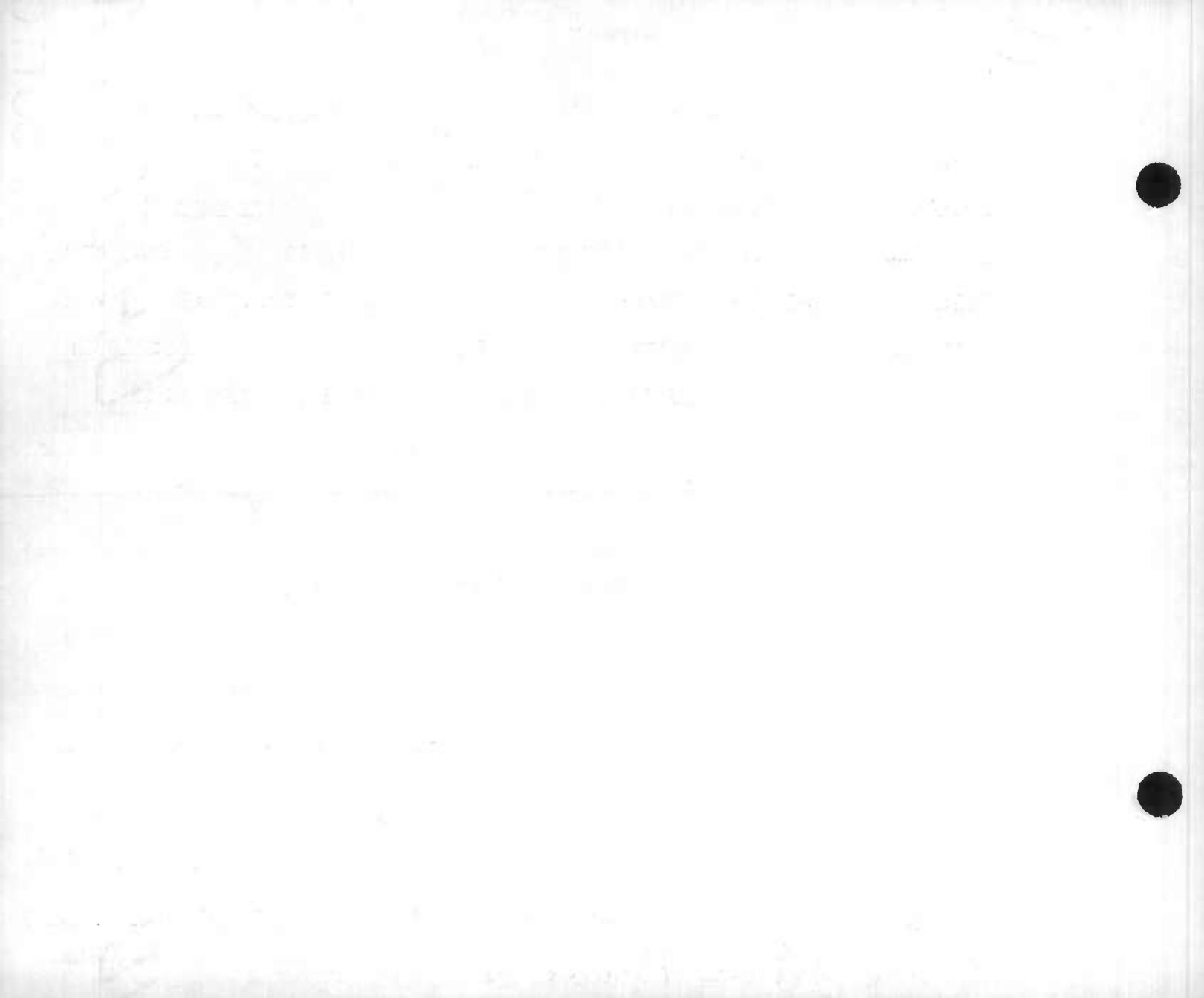
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23101				
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR				
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			AUGUST 03, 1984								
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
MALE			WHITE			05/12/ 1897		87 YRS.						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		M.D. WASHINGTON				
MARYLAND			UNITED STATES											
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY						
HAGERSTOWN			WASHINGTON COUNTY HOSPITAL			MECHANIC		AUTOMOTIVE						
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE					
MARYLAND			WASHINGTON		HANCOCK				108 FULTON STREET		21750			
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
CHARLES MANNING			CARRIE McCULLOUGH											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT		ADDRESS						
NO			213 10 8308			MRS. ESTALENE MANNING		SAME AS 13						
18 CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and 1(c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.				
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive pulmonary disease														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arterio sclerotic Heart Disease with congestive failure														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (the hospital) attended the deceased from 8-3 1984, to 8-3 1984, that (I) (we) last saw the deceased alive on 8-3 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>John Spencer</i>										DEGREE		22c DATE SIGNED 8-3-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles P. Spencer</i>			22e. ADDRESS 1198 Party Ave Hagerstown Md.							ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 08/06/84			23c. NAME OF CEMETERY OR CREMATORIAL WARFORDSBURG PRESBYT.			23d. LOCATION CITY OR TOWN WARFORDSBURG, COUNTY FULTON, STATE PA. 17267					
24 FUNERAL DIRECTOR NAME <i>Richard J. Groves Hancock MD</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG 9 1984			25b. REGISTRAR'S SIGNATURE <i>Julie Davidson Pendell</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do every thing
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23102					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
SALLIE			RUTH		MARKER	Aug. 5, 1984						125 P.M.			
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.				
Female			White		Month October 19, 1898 Year	85			MONTHS	DAYS	HOURS	YRS			
7c. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			U.S.A.			Washington County									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IE NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown			AVALON Manor Nursing Home						Teller			Bank			
11a. STATE			11b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			13f. ADDRESS			
Maryland			Frederick		Myersville	YES <input checked="" type="checkbox"/>			412 Main Street 21773			243 Robinwood Drive Hagerstown, MD 21740			
14. FATHER'S NAME			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST							
Carlton			P.	Marker	Orpha	C.		Schroyer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.						17. INFORMANT			ADDRESS			
No			213-03-0632						Ruth Poffenberger			243 Robinwood Drive Hagerstown, MD 21740			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) Congestive Heart Failure										24 hrs					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) Stroke 48 hrs					
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis yrs															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. none 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) none			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 5, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			May 26, 1981, to Aug 5, 1984												
22b. SIGNATURE W.W. Lesh M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-6-84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William W. Lesh M.D.			22e. ADDRESS 411 Division Ave Hagerstown, Md.												
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE Aug. 8, 1984			23c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran			23d. LOCATION CITY OR TOWN Myersville			COUNTY Frederick			
23e. FUNERAL DIRECTOR Ricketts Funeral Home			23f. ADDRESS 504 Main Street Myersville, MD 21773			23g. DATE REC'D. BY REGISTERED MAIL AUG 13 1984			23h. DATE OF DEATH 1984			23i. PLACE OF DEATH Johnston Funeral			

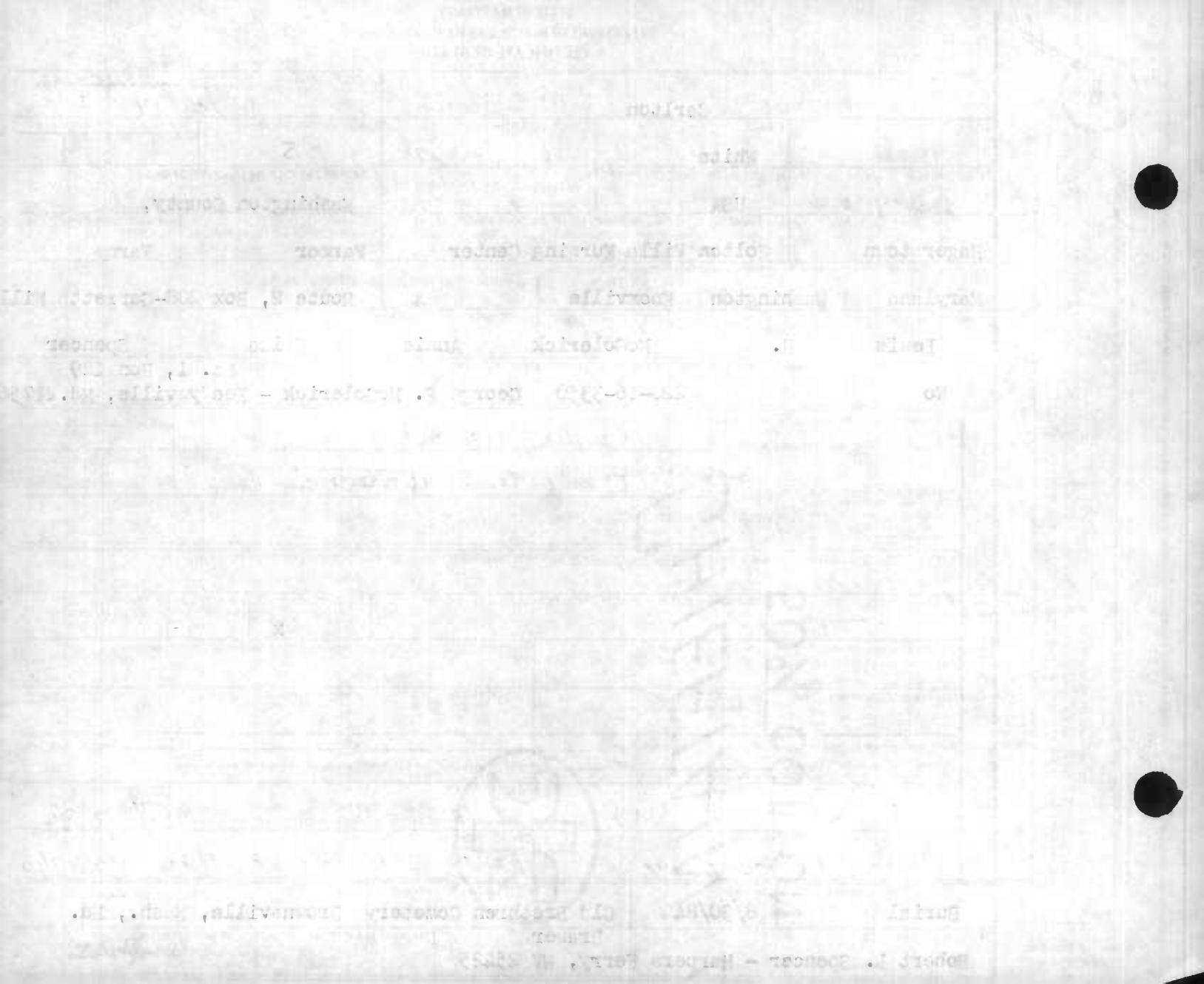
A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			8/27/84	2 PM				
Emory Carlton McGolerick																	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White			11 18 78			85			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.					
Maryland			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington County, MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Colton Villa Nursing Center									Farmer			Farms		
13a. STATE Maryland			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Route 2, Box 208-Garretts Mill			21758					
14. FATHER'S NAME Lewis H. McGolerick			15. MOTHER'S MAIDEN NAME Annie Eliza Spencer														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-16-3350			17. INFORMANT George F. McGolerick - Keedysville, Md. 21756			ADDRESS Rt. 1, Box 129								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordia arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															22c. DATE SIGNED 8/27/84		
22b. SIGNATURE <u>Robert L. Spencer</u>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Spencer			22e. ADDRESS 1602 Oak Hill Rd. Hagerstown, Md. 21740														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/30/84			23c. NAME OF CEMETERY OR CREMATORIAL Old Brethren Cemetery			23d. LOCATION CITY OR TOWN Brownsville, Wash., Md.			COUNTY	STATE				
24. FUNERAL DIRECTOR NAME Robert L. Spencer - Harpers Ferry, WV 25425			ADDRESS Drawer C			25a. DATE REC'D. BY REGISTRAR SEP 6 1984			25b. REGISTRAR'S SIGNATURE Robert L. Spencer								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, Page 3

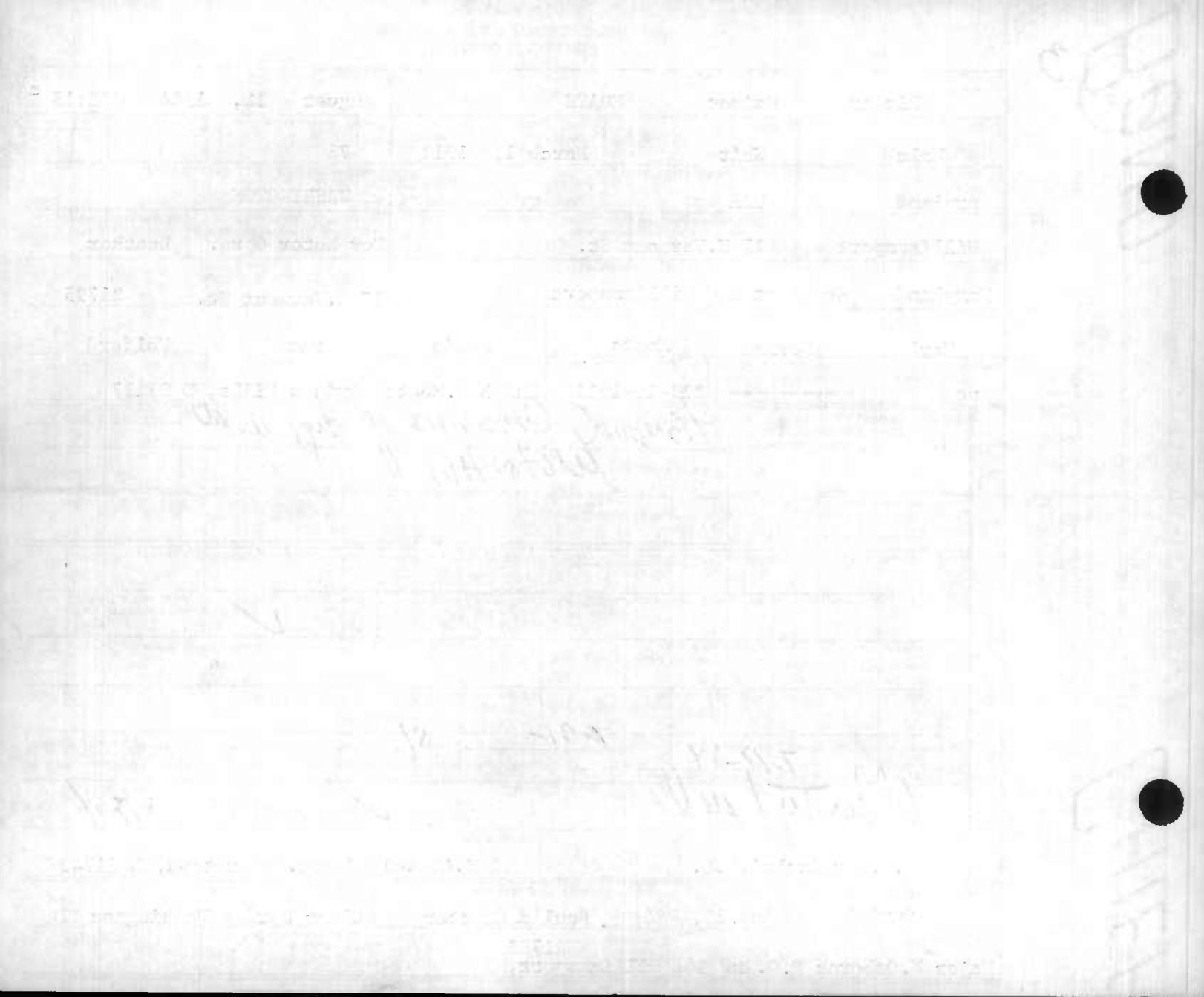
should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23104					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Richard Gaines					MOATS			August 12, 1984						12:15 a	
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White			March 1, 1912			72			MONTHS	YEARS	MONTHS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			WASHINGTON MD.				
Maryland		USA													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Williamsport		17 N. Vermont St.						Tow Motor Opre.			Leather				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE					
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Williamsport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 17 N. Vermont St. 21795						
14. FATHER'S NAME FIRST		MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST	
Earl		Norman			Moats			Annie			Orea			Wolford	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line in (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
no		2 b5-18-1211						Ralph F. Moats			Owings Mills, MD 21117				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										(b)					
DUE TO, OR AS A CONSEQUENCE (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-21, 1987, to 19, 1987, that (I) (we) last saw the deceased alive on 7-22-87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I have had (did not) view the body after death.)															
22b. SIGNATURE <i>E.R. Lardizabal, M.D.</i>										DEGREE					
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22d. DATE SIGNED 8/13/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
E.R. Lardizabal, M.D.		382 S. Cleveland Ave. Hagerstown, MD 21740													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial		Aug. 15, 1984		St. Paul's Cemetery			Clear Spring Washington MD								
24. FUNERAL DIRECTOR NAME Major M. Osborne P.O. Box # 348 Williamsport, MD										25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE AUG 20 1984					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, unless it is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23105						
1. DECEASED NAME (TYPE OR PRINT)			FIRST Harold HAROLD			MIDDLE Wendrick W.			LAST MOORE MOORE			2d. DATE OF DEATH 8-9-84	MONTH	DAY	YEAR	2d. HOUR 6 AM
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH Jan. 25, 1914 YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN.		
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington			MD.				
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION Metal Worker			12b. KIND OF BUSINESS OR INDUSTRY Fairchild							
13a. STATE MD			13b. COUNTY Wash.			13c. CITY OR TOWN Smithsburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt. 4, Box 45 21783				
14. FATHER'S NAME FIRST Morhl			MIDDLE R.			LAST Moore			15. MOTHER'S MAIDEN NAME FIRST Maude			MIDDLE - LAST Stull				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. -			17. INFORMANT Mrs. Nellie M. Moore, Smithsburg, MD			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Colon with</u>																
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatic, Pulmonary, Bone Metastasis</u>																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Spinal Cord Compression Secondary to metastasis</u>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (the hospital) attended the deceased from 8-9 1984 to 8-9 1984, that (I) (we) last saw the deceased alive on 8-9 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22e. DATE SIGNED 8-9-84						
22f. SIGNATURE <u>Ervin Wagler Jr.</u>										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22g. PHYSICIAN'S NAME (TYPE OR PRINT)										22h. ADDRESS						
23h. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 13, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Park			23d. LOCATION Hagerstown, Wash., MD			STATE				
24. FUNERAL DIRECTOR NAME Dennis L. Davis Davis Funeral Home, Smithsburg, MD 21783										25a. DATE REC'D. BY REGISTRAR AUG 15 1984		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson Pendle</u>				

CR (student) except in off season. ~~REASIDE~~

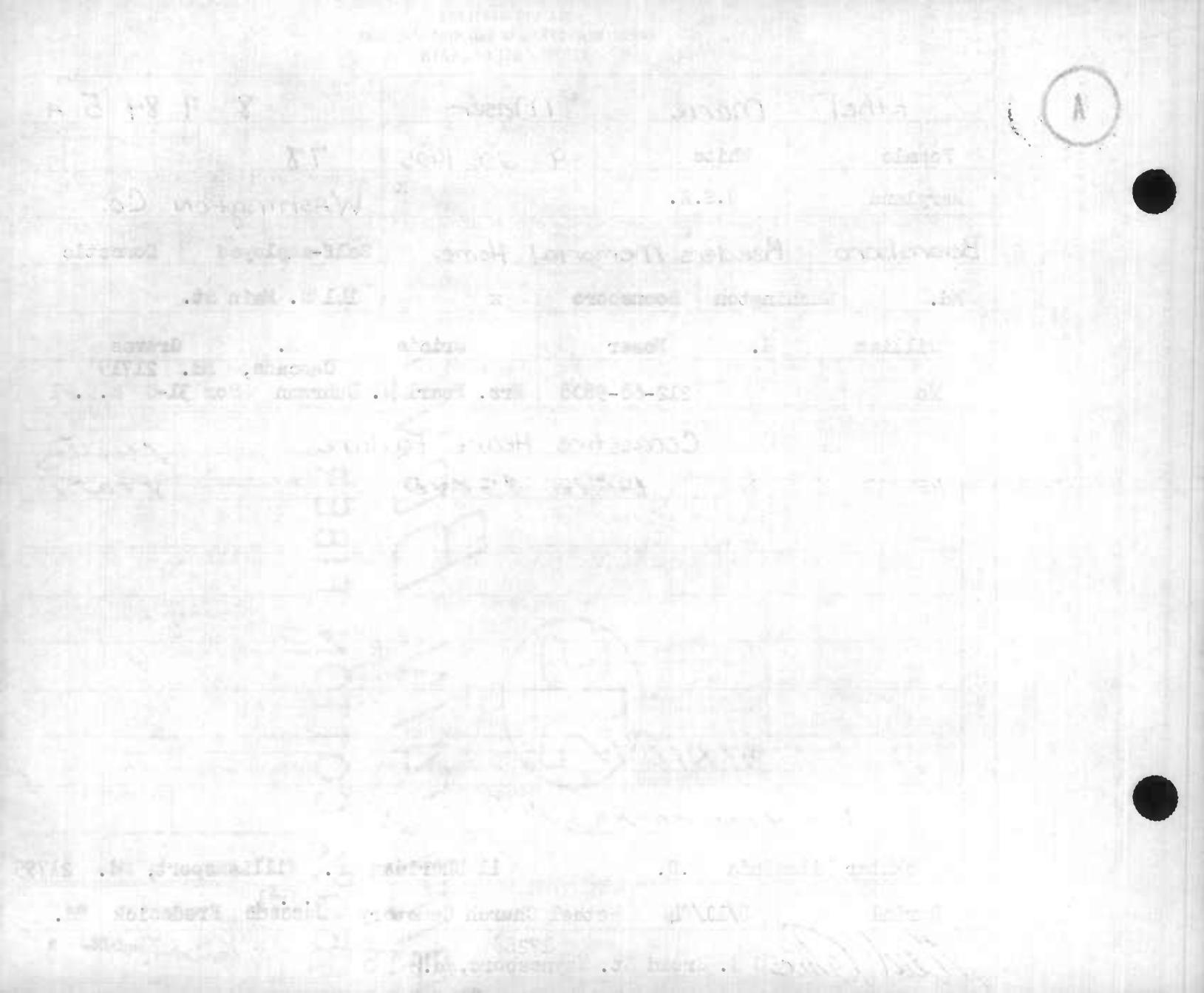
Jazzon 2014-2015
Jazzon 2014-2015

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If Item 21 is marked **death**, it shows any injury, or other traumatic event, the medical examiner may be notified at once.

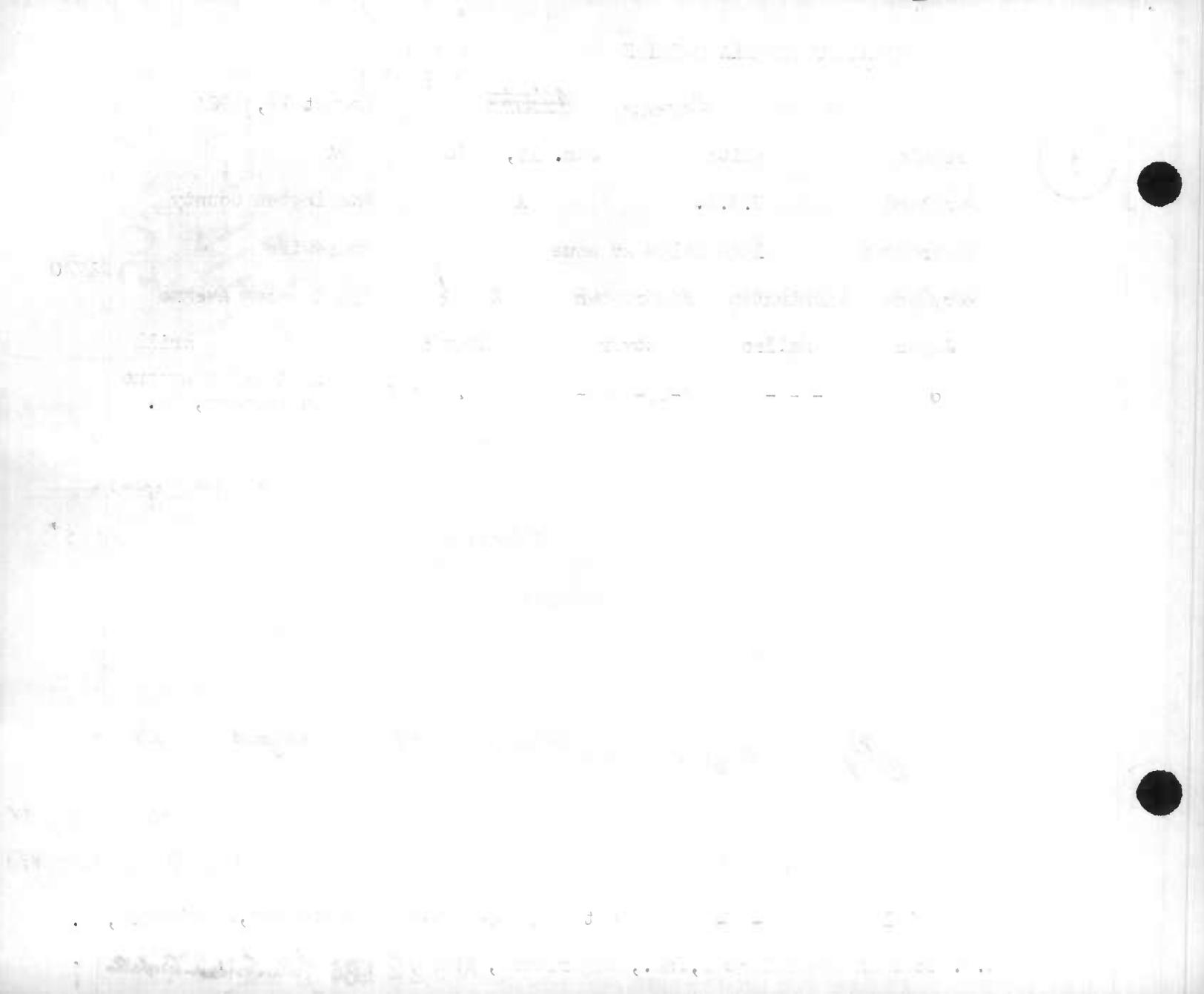
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23106						
												REG. NO.						
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH			MONTH DAY YEAR	2b HOUR					
			Ethel Marie Moser						8 9 84			5 A M						
3. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.				
Female			White			MONTH 9 DAY 20 YEAR 1905			77			MONTHS	DAYS	HOURS	MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington Co.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Boonsboro			Reeders Memorial Home			Self-employed			Domestic									
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21713					
Md.			Washington		Boonsboro		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			141 S. Main St.								
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			Cascade, Md. 21719			
William			H. Moser			Bricie M. Graves			No			212-68-9808			Mrs. Pearl W. Buhrman Box 31-C R.D.#1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Month years</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Due to ASCVD</i>																		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>None</i>																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>8/18/84</i> , 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <i>8/18/84</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>Mokhtar Milanimia M.D.</i>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23c. NAME OF CEMETERY OR CREMATORIAL LOCATION Bethel Church Cemetery			23d. LOCATION CASKET #1 CASKET #2 CASKET #3 CASKET #4 CASKET #5 CASKET #6 CASKET #7 CASKET #8 CASKET #9 CASKET #10 CASKET #11 CASKET #12 CASKET #13 CASKET #14 CASKET #15 CASKET #16 CASKET #17 CASKET #18 CASKET #19 CASKET #20 CASKET #21 CASKET #22 CASKET #23 CASKET #24 CASKET #25 CASKET #26 CASKET #27 CASKET #28 CASKET #29 CASKET #30 CASKET #31 CASKET #32 CASKET #33 CASKET #34 CASKET #35 CASKET #36 CASKET #37 CASKET #38 CASKET #39 CASKET #40 CASKET #41 CASKET #42 CASKET #43 CASKET #44 CASKET #45 CASKET #46 CASKET #47 CASKET #48 CASKET #49 CASKET #50 CASKET #51 CASKET #52 CASKET #53 CASKET #54 CASKET #55 CASKET #56 CASKET #57 CASKET #58 CASKET #59 CASKET #60 CASKET #61 CASKET #62 CASKET #63 CASKET #64 CASKET #65 CASKET #66 CASKET #67 CASKET #68 CASKET #69 CASKET #70 CASKET #71 CASKET #72 CASKET #73 CASKET #74 CASKET #75 CASKET #76 CASKET #77 CASKET #78 CASKET #79 CASKET #80 CASKET #81 CASKET #82 CASKET #83 CASKET #84 CASKET #85 CASKET #86 CASKET #87 CASKET #88 CASKET #89 CASKET #90 CASKET #91 CASKET #92 CASKET #93 CASKET #94 CASKET #95 CASKET #96 CASKET #97 CASKET #98 CASKET #99 CASKET #100 CASKET #101 CASKET #102 CASKET #103 CASKET #104 CASKET #105 CASKET #106 CASKET #107 CASKET #108 CASKET #109 CASKET #110 CASKET #111 CASKET #112 CASKET #113 CASKET #114 CASKET #115 CASKET #116 CASKET #117 CASKET #118 CASKET #119 CASKET #120 CASKET #121 CASKET #122 CASKET #123 CASKET #124 CASKET #125 CASKET #126 CASKET #127 CASKET #128 CASKET #129 CASKET #130 CASKET #131 CASKET #132 CASKET #133 CASKET #134 CASKET #135 CASKET #136 CASKET #137 CASKET #138 CASKET #139 CASKET #140 CASKET #141 CASKET #142 CASKET #143 CASKET #144 CASKET #145 CASKET #146 CASKET #147 CASKET #148 CASKET #149 CASKET #150 CASKET #151 CASKET #152 CASKET #153 CASKET #154 CASKET #155 CASKET #156 CASKET #157 CASKET #158 CASKET #159 CASKET #160 CASKET #161 CASKET #162 CASKET #163 CASKET #164 CASKET #165 CASKET #166 CASKET #167 CASKET #168 CASKET #169 CASKET #170 CASKET #171 CASKET #172 CASKET #173 CASKET #174 CASKET #175 CASKET #176 CASKET #177 CASKET #178 CASKET #179 CASKET #180 CASKET #181 CASKET #182 CASKET #183 CASKET #184 CASKET #185 CASKET #186 CASKET #187 CASKET #188 CASKET #189 CASKET #190 CASKET #191 CASKET #192 CASKET #193 CASKET #194 CASKET #195 CASKET #196 CASKET #197 CASKET #198 CASKET #199 CASKET #200 CASKET #201 CASKET #202 CASKET #203 CASKET #204 CASKET #205 CASKET #206 CASKET #207 CASKET #208 CASKET #209 CASKET #210 CASKET #211 CASKET #212 CASKET #213 CASKET #214 CASKET #215 CASKET #216 CASKET #217 CASKET #218 CASKET #219 CASKET #220 CASKET #221 CASKET #222 CASKET #223 CASKET #224 CASKET #225 CASKET #226 CASKET #227 CASKET #228 CASKET #229 CASKET #230 CASKET #231 CASKET #232 CASKET #233 CASKET #234 CASKET #235 CASKET #236 CASKET #237 CASKET #238 CASKET #239 CASKET #240 CASKET #241 CASKET #242 CASKET #243 CASKET #244 CASKET #245 CASKET #246 CASKET #247 CASKET #248 CASKET #249 CASKET #250 CASKET #251 CASKET #252 CASKET #253 CASKET #254 CASKET #255 CASKET #256 CASKET #257 CASKET #258 CASKET #259 CASKET #260 CASKET #261 CASKET #262 CASKET #263 CASKET #264 CASKET #265 CASKET #266 CASKET #267 CASKET #268 CASKET #269 CASKET #270 CASKET #271 CASKET #272 CASKET #273 CASKET #274 CASKET #275 CASKET #276 CASKET #277 CASKET #278 CASKET #279 CASKET #280 CASKET #281 CASKET #282 CASKET #283 CASKET #284 CASKET #285 CASKET #286 CASKET #287 CASKET #288 CASKET #289 CASKET #290 CASKET #291 CASKET #292 CASKET #293 CASKET #294 CASKET #295 CASKET #296 CASKET #297 CASKET #298 CASKET #299 CASKET #300 CASKET #301 CASKET #302 CASKET #303 CASKET #304 CASKET #305 CASKET #306 CASKET #307 CASKET #308 CASKET #309 CASKET #310 CASKET #311 CASKET #312 CASKET #313 CASKET #314 CASKET #315 CASKET #316 CASKET #317 CASKET #318 CASKET #319 CASKET #320 CASKET #321 CASKET #322 CASKET #323 CASKET #324 CASKET #325 CASKET #326 CASKET #327 CASKET #328 CASKET #329 CASKET #330 CASKET #331 CASKET #332 CASKET #333 CASKET #334 CASKET #335 CASKET #336 CASKET #337 CASKET #338 CASKET #339 CASKET #340 CASKET #341 CASKET #342 CASKET #343 CASKET #344 CASKET #345 CASKET #346 CASKET #347 CASKET #348 CASKET #349 CASKET #350 CASKET #351 CASKET #352 CASKET #353 CASKET #354 CASKET #355 CASKET #356 CASKET #357 CASKET #358 CASKET #359 CASKET #360 CASKET #361 CASKET #362 CASKET #363 CASKET #364 CASKET #365 CASKET #366 CASKET #367 CASKET #368 CASKET #369 CASKET #370 CASKET #371 CASKET #372 CASKET #373 CASKET #374 CASKET #375 CASKET #376 CASKET #377 CASKET #378 CASKET #379 CASKET #380 CASKET #381 CASKET #382 CASKET #383 CASKET #384 CASKET #385 CASKET #386 CASKET #387 CASKET #388 CASKET #389 CASKET #390 CASKET #391 CASKET #392 CASKET #393 CASKET #394 CASKET #395 CASKET #396 CASKET #397 CASKET #398 CASKET #399 CASKET #400 CASKET #401 CASKET #402 CASKET #403 CASKET #404 CASKET #405 CASKET #406 CASKET #407 CASKET #408 CASKET #409 CASKET #410 CASKET #411 CASKET #412 CASKET #413 CASKET #414 CASKET #415 CASKET #416 CASKET #417 CASKET #418 CASKET #419 CASKET #420 CASKET #421 CASKET #422 CASKET #423 CASKET #424 CASKET #425 CASKET #426 CASKET #427 CASKET #428 CASKET #429 CASKET #430 CASKET #431 CASKET #432 CASKET #433 CASKET #434 CASKET #435 CASKET #436 CASKET #437 CASKET #438 CASKET #439 CASKET #440 CASKET #441 CASKET #442 CASKET #443 CASKET #444 CASKET #445 CASKET #446 CASKET #447 CASKET #448 CASKET #449 CASKET #450 CASKET #451 CASKET #452 CASKET #453 CASKET #454 CASKET #455 CASKET #456 CASKET #457 CASKET #458 CASKET #459 CASKET #460 CASKET #461 CASKET #462 CASKET #463 CASKET #464 CASKET #465 CASKET #466 CASKET #467 CASKET #468 CASKET #469 CASKET #470 CASKET #471 CASKET #472 CASKET #473 CASKET #474 CASKET #475 CASKET #476 CASKET #477 CASKET #478 CASKET #479 CASKET #480 CASKET #481 CASKET #482 CASKET #483 CASKET #484 CASKET #485 CASKET #486 CASKET #487 CASKET #488 CASKET #489 CASKET #490 CASKET #491 CASKET #492 CASKET #493 CASKET #494 CASKET #495 CASKET #496 CASKET #497 CASKET #498 CASKET #499 CASKET #500 CASKET #501 CASKET #502 CASKET #503 CASKET #504 CASKET #505 CASKET #506 CASKET #507 CASKET #508 CASKET #509 CASKET #510 CASKET #511 CASKET #512 CASKET #513 CASKET #514 CASKET #515 CASKET #516 CASKET #517 CASKET #518 CASKET #519 CASKET #520 CASKET #521 CASKET #522 CASKET #523 CASKET #524 CASKET #525 CASKET #526 CASKET #527 CASKET #528 CASKET #529 CASKET #530 CASKET #531 CASKET #532 CASKET #533 CASKET #534 CASKET #535 CASKET #536 CASKET #537 CASKET #538 CASKET #539 CASKET #540 CASKET #541 CASKET #542 CASKET #543 CASKET #544 CASKET #545 CASKET #546 CASKET #547 CASKET #548 CASKET #549 CASKET #550 CASKET #551 CASKET #552 CASKET #553 CASKET #554 CASKET #555 CASKET #556 CASKET #557 CASKET #558 CASKET #559 CASKET #560 CASKET #561 CASKET #562 CASKET #563 CASKET #564 CASKET #565 CASKET #566 CASKET #567 CASKET #568 CASKET #569 CASKET #570 CASKET #571 CASKET #572 CASKET #573 CASKET #574 CASKET #575 CASKET #576 CASKET #577 CASKET #578 CASKET #579 CASKET #580 CASKET #581 CASKET #582 CASKET #583 CASKET #584 CASKET #585 CASKET #586 CASKET #587 CASKET #588 CASKET #589 CASKET #590 CASKET #591 CASKET #592 CASKET #593 CASKET #594 CASKET #595 CASKET #596 CASKET #597 CASKET #598 CASKET #599 CASKET #600 CASKET #601 CASKET #602 CASKET #603 CASKET #604 CASKET #605 CASKET #606 CASKET #607 CASKET #608 CASKET #609 CASKET #610 CASKET #611 CASKET #612 CASKET #613 CASKET #614 CASKET #615 CASKET #616 CASKET #617 CASKET #618 CASKET #619 CASKET #620 CASKET #621 CASKET #622 CASKET #623 CASKET #624 CASKET #625 CASKET #626 CASKET #627 CASKET #628 CASKET #629 CASKET #630 CASKET #631 CASKET #632 CASKET #633 CASKET #634 CASKET #635 CASKET #636 CASKET #637 CASKET #638 CASKET #639 CASKET #640 CASKET #641 CASKET #642 CASKET #643 CASKET #644 CASKET #645 CASKET #646 CASKET #647 CASKET #648 CASKET #649 CASKET #650 CASKET #651 CASKET #652 CASKET #653 CASKET #654 CASKET #655 CASKET #656 CASKET #657 CASKET #658 CASKET #659 CASKET #660 CASKET #661 CASKET #662 CASKET #663 CASKET #664 CASKET #665 CASKET #666 CASKET #667 CASKET #668 CASKET #669 CASKET #670 CASKET #671 CASKET #672 CASKET #673 CASKET #674 CASKET #675 CASKET #676 CASKET #677 CASKET #678 CASKET #679 CASKET #680 CASKET #681 CASKET #682 CASKET #683 CASKET #684 CASKET #685 CASKET #686 CASKET #687 CASKET #688 CASKET #689 CASKET #690 CASKET #691 CASKET #692 CASKET #693 CASKET #694 CASKET #695 CASKET #696 CASKET #697 CASKET #698 CASKET #699 CASKET #700 CASKET #701 CASKET #702 CASKET #703 CASKET #704 CASKET #705 CASKET #706 CASKET #707 CASKET #708 CASKET #709 CASKET #710 CASKET #711 CASKET #712 CASKET #713 CASKET #714 CASKET #715 CASKET #716 CASKET #717 CASKET #718 CASKET #719 CASKET #720 CASKET #721 CASKET #722 CASKET #723 CASKET #724 CASKET #725 CASKET #726 CASKET #727 CASKET #728 CASKET #729 CASKET #730 CASKET #731 CASKET #732 CASKET #733 CASKET #734 CASKET #735 CASKET #736 CASKET #737 CASKET #738 CASKET #739 CASKET #740 CASKET #741 CASKET #742 CASKET #743 CASKET #744 CASKET #745 CASKET #746 CASKET #747 CASKET #748 CASKET #749 CASKET #750 CASKET #751 CASKET #752 CASKET #753 CASKET #754 CASKET #755 CASKET #756 CASKET #757 CASKET #758 CASKET #759 CASKET #760 CASKET #761 CASKET #762 CASKET #763 CASKET #764 CASKET #765 CASKET #766 CASKET #767 CASKET #768 CASKET #769 CASKET #770 CASKET #771 CASKET #772 CASKET #773 CASKET #774 CASKET #775 CASKET #776 CASKET #777 CASKET #778 CASKET #779 CASKET #780 CASKET #781 CASKET #782 CASKET #783 CASKET #784 CASKET #785 CASKET #786 CASKET #787 CASKET #788 CASKET #789 CASKET #790 CASKET #791 CASKET #792 CASKET #793 CASKET #794 CASKET #795 CASKET #796 CASKET #797 CASKET #798 CASKET #799 CASKET #800 CASKET #801 CASKET #802 CASKET #803 CASKET #804 CASKET #805 CASKET #806 CASKET #807 CASKET #808 CASKET #809 CASKET #810 CASKET #811 CASKET #812 CASKET #813 CASKET #814 CASKET #815 CASKET #816 CASKET #817 CASKET #818 CASKET #819 CASKET #820 CASKET #821 CASKET #822 CASKET #823 CASKET #824 CASKET #825 CASKET #826 CASKET #827 CASKET #828 CASKET #829 CASKET #830 CASKET #831 CASKET #832 CASKET #833 CASKET #834 CASKET #835 CASKET #836 CASKET #837 CASKET #838 CASKET #839 CASKET #840 CASKET #841 CASKET #842 CASKET #843 CASKET #844 CASKET #845 CASKET #846 CASKET #847 CASKET #848 CASKET #849 CASKET #850 CASKET #851 CASKET #852 CASKET #853 CASKET #854 CASKET #855 CASKET #856 CASKET #857 CASKET #858 CASKET #859 CASKET #860 CASKET #861 CASKET #862 CASKET #863 CASKET #864 CASKET #865 CASKET #866 CASKET #867 CASKET #868 CASKET #869 CASKET #870 CASKET #871 CASKET #872 CASKET #873 CASKET #874 CASKET #875 CASKET #876 CASKET #877 CASKET #878 CASKET #879 CASKET #880 CASKET #881 CASKET #882 CASKET #883 CASKET #884 CASKET #885 CASKET #886 CASKET #887 CASKET #888 CASKET #889 CASKET #890 CASKET #891 CASKET #892 CASKET #893 CASKET #894 CASKET #895 CASKET #896 CASKET #897 CASKET #898 CASKET #899 CASKET #900 CASKET #901 CASKET #902 CASKET #903 CASKET #904 CASKET #905 CASKET #906 CASKET #907 CASKET #908 CASKET #909 CASKET #910 CASKET #911 CASKET #912 CASKET #913 CASKET #914 CASKET #915 CASKET #916 CASKET #917 CASKET #918 CASKET #919 CASKET #920 CASKET #921 CASKET #922 CASKET #923 CASKET #924 CASKET #925 CASKET #926 CASKET #927 CASKET #928 CASKET #929 CASKET #930 CASKET #931 CASKET #932 CASKET #933 CASKET #934 CASKET #935 CASKET #936 CASKET #937 CASKET #938 CASKET #939 CASKET #940 CASKET #941 CASKET #942 CASKET #943 CASKET #944 CASKET #945 CASKET #946 CASKET #947 CASKET #948 CASKET #949 CASKET #950 CASKET #951 CASKET #952 CASKET #953 CASKET #954 CASKET #955 CASKET #956 CASKET #957 CASKET #958 CASKET #959 CASKET #960 CASKET #961 CASKET #962 CASKET #963 CASKET #964 CASKET #965 CASKET #966 CASKET #967 CASKET #968 CASKET #969 CASKET #970 CASKET #971 CASKET #972 CASKET #973 CASKET #974 CASKET #975 CASKET #976 CASKET #977 CASKET #978 CASKET #979 CASKET #980 CASKET #981 CASKET #982 CASKET #983 CASKET #984 CASKET #985 CASKET #986 CASKET #987 CASKET #988 CASKET #989 CASKET #990 CASKET #991 CASKET #992 CASKET #993 CASKET #994 CASKET #995 CASKET #996 CASKET #997 CASKET #998 CASKET #999 CASKET #1000									

A



2K
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 2 hours of death.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MARGARET ESTELLA NEIKIRK CERTIFICATE OF DEATH										23101				
1 - STATE REGISTRAR			REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2d. DATE OF DEATH MONTH DAY YEAR				2d. HOUR	
Margaret Estella Neikirk									August 18, 1984				M	
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female			White		Jan. 15, 1890		94				IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County				MD.			
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1344 Salem Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 134 4 Salem Avenue 21740					
14. FATHER'S NAME FIRST James			MIDDLE Dallas		LAST Hoover		15. MOTHER'S MAIDEN NAME FIRST Amanda				MIDDLE Brill LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. - - - 214-09-6434-D		17. INFORMANT Ralph V. Neikirk		18. ADDRESS 1344 Salem Avenue Hagerstown, Md.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			myocardial infarction											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular disease				years							
			DUE TO, OR AS A CONSEQUENCE OF (c) advanced age				years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>August 19, 1979</u> to <u>August 19, 1984</u> , that (we) last saw the deceased alive on <u>August 19, 1984</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <u>Laura Waldron M.D.</u>			DEGREE				22c. DATE SIGNED <u>August 20, 1984</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Laura Waldron M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-21-84		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Washington, Md.		23e. COUNTY Md.		23f. STATE			
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown,			ADDRESS AUG 22 1984				25a. DATE REC'D. BY REGISTRAR AUG 22 1984		25b. REGISTRAR'S SIGNATURE <u>Julia K. Kinsler Pendell</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, if retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23108						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH			MONTH	DAY	YEAR	21. HOUR				
Rosie unknown					NICHOLAS	8-16-84					8-16-84	2 PM				
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR						
FEMALE			W	MONTH 11 DAY 23 YEAR 1913			= 67 YRS.			MONTHS DAYS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Illinois			USA						Washington							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown			Washington County Hospital			housewife						21740				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE						
13. STATE			13b. COUNTY			13c. CITY OR TOWN			2750 Pennsylvania Ave.							
Maryland			Washington			Hagerstown										
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST						
Dick					George	Mary										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			218-40-3644			Alex Nicholas, Hagerstown, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Cardiac arrest -						
DUE TO, OR AS A CONSEQUENCE OF (b) acute myocardial infarction																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DUE TO, OR AS A CONSEQUENCE OF (c) hyper tension																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE										DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Asperic Latived up										22e. ADDRESS			8/16/84			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial										23c. NAME OF CEMETERY OR CREMATORIAL Aug. 21, 1984 Evergreen Cem.			23d. LOCATION CITY OR TOWN Hillside, COUNTY N.J.			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740										25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
										AUG 27 1984 John Miller, RN						

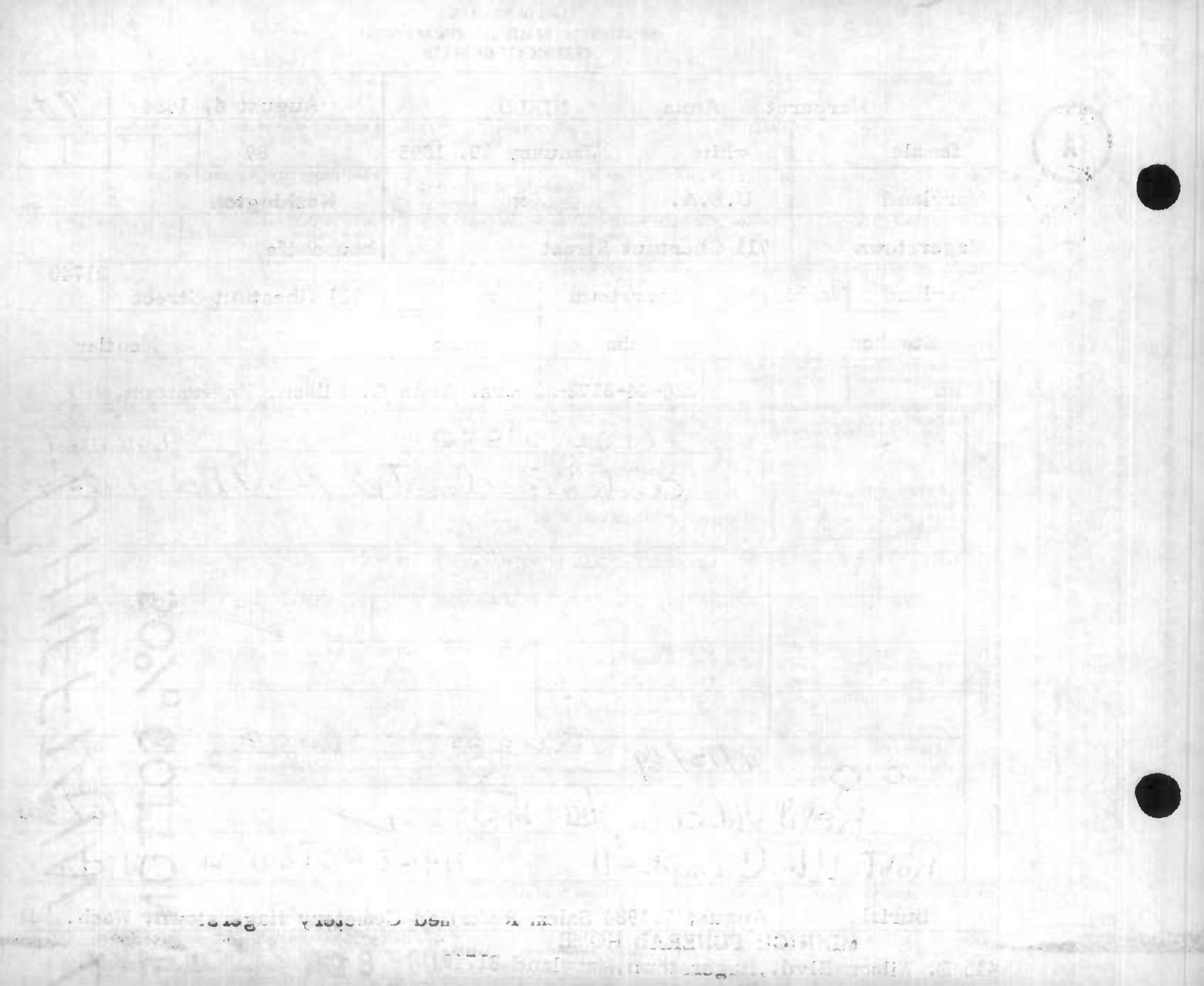
211 88

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

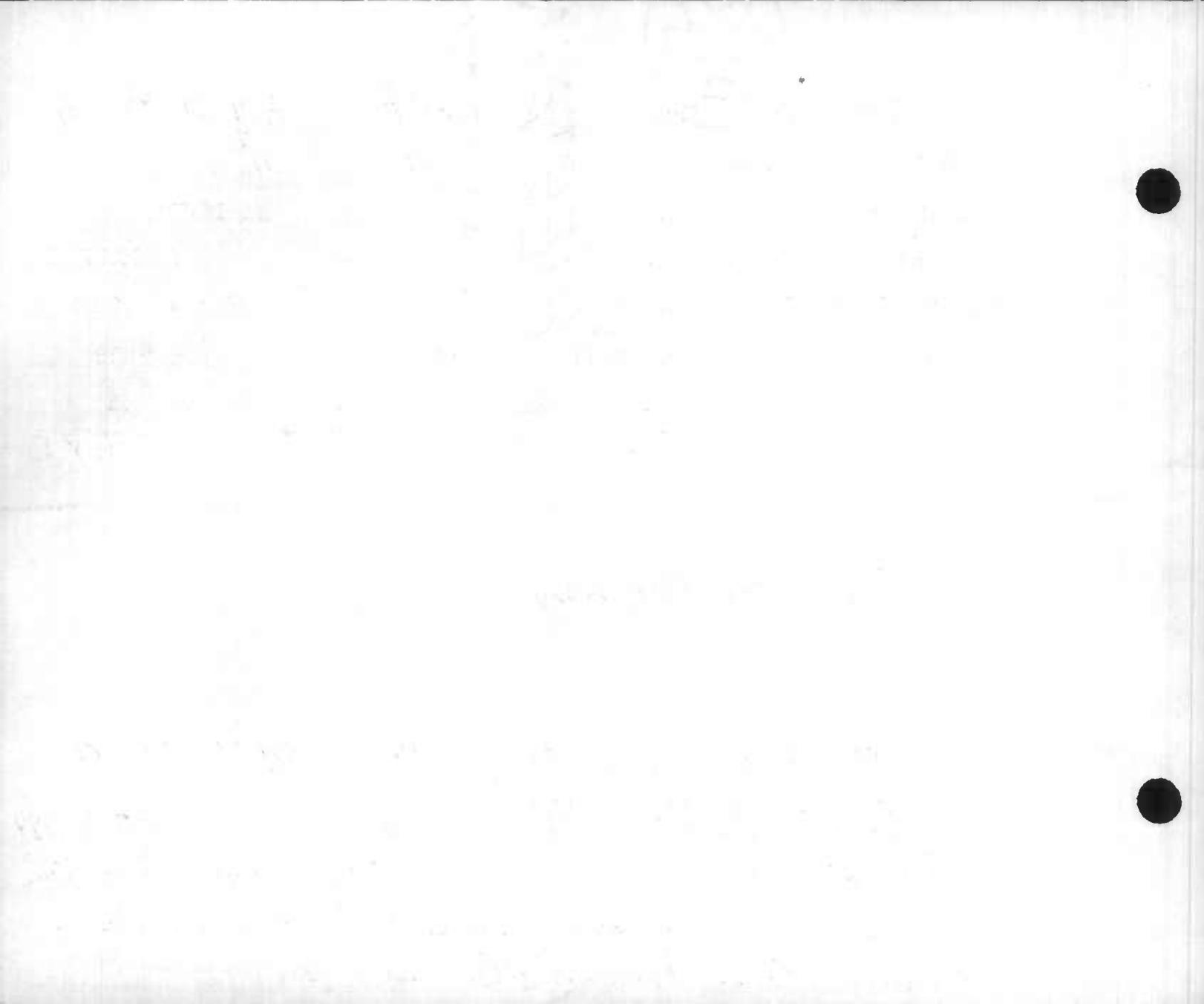
IMPORTANT: If item 21 is marked or item 8 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23109		
												REG. NO.		
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Margaret Anna NIELD						August 4, 1984			78 M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
female		white		January 10, 1895			89 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.							
Maryland		U.S.A.												
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 711 Chestnut Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 711 Chestnut Street				
14. FATHER'S NAME FIRST Stephen		MIDDLE		LAST Heim			15. MOTHER'S MAIDEN NAME FIRST Anna			MIDDLE			LAST Mentler	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT			17. ADDRESS							
no		220-44-8172-J		Mrs. Anna G. Wilson, Hagerstown, MD										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>asystole</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immed</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic Heart Disease 15 yr</i> } } DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 55</i> , 19 <i>84</i> , to <i>Aug 4</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>4/12/84</i> , 19 <i>84</i> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>Robert V.H. Campbell MD</i>			22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>8/6/84</i>								
22e. ADDRESS <i>HAGERSTOWN MD.</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE August 7, 1984 Salem Reformed Cemetery Hagerstown, Wash., MD			23c. LOCATION CITY OR TOWN COUNTY STATE								
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i> ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Maryland 21741</i>			25a. DATE REC'D. BY REGISTRAR <i>AUG 8 1984</i>			25b. REGISTRAR'S SIGNATURE <i>Juli Davidson-Rendell</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be reigned by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after the death occurred with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23110	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Theodore Tilghman					Northcraft	Aug 29			1984	29	84	11:00 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 1 HRS	
MALE		WHITE		MAY 4, 1907			77 YRS.			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
PENNSYLVANIA		UNITED STATES					WASHINGTON,						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
HAGERSTOWN		WASHINGTON COUNTY HOSPITAL		FARMER			AGRICULTURE			999999			
13a. STATE PENNSYLVANIA		13b. COUNTY FULTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE RD 1 BOX 55			17211			
14. FATHER'S NAME VERNON		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME NORTHCRAFT			MIDDLE	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS						
NO		217 12 2497		WILLA P. NORTHCRAFT			SAME AS 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days 5	
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pancreatic Carcinoma</u> -													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> (I) WE (II) WE (III) WE (IV) WE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (we) attended the deceased from Aug 29 1984 to Aug 29 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I did) (did not) view the body after death.													
22b. SIGNATURE <u>Robert Brull</u>		MD		22c. DATE SIGNED <u>Sept 4 1984</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert Brull</u>		22e. ADDRESS <u>1459 Potomac Ave. Hagerstown</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 09/01/1984		23c. NAME OF CEMETERY OR CREMATORIAL FAIRVIEW			23d. LOCATION CITY OR TOWN ARTEMAS, FULTON, PENNA.						
24. FUNERAL DIRECTOR NAME <u>Julia Davidson Pendleton</u>		ADDRESS <u>21750 Shreve Hancock Rd.</u>		25a. DATE REC'D. BY REGISTRAR SEP 7 1984			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson Pendleton</u>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23111
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<u>OSCAR</u>			<u>W.</u>	<u>NYE</u>		<u>8/19/84</u>				<u>7:30 A.M.</u>		
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			
<u>Male</u>			<u>White</u>		<u>9</u> <u>3</u> <u>1902</u>	<u>81</u>				<u>MONTHS</u>	<u>YEARS</u>	
7a. BIRTHPLACE <u>COUNTRY</u> <u>Chambersburg,</u>			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Western Maryland Center</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>supervisor</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Pa. R.R.</u>				
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Washington</u>		13c. CITY OR TOWN <u>Hagerstown</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>Walnut Towers 21740</u>				
14. FATHER'S NAME FIRST <u>Harvey</u>			MIDDLE <u>Clayton</u>	LAST <u>Nye</u>	15. MOTHER'S MAIDEN NAME FIRST <u>Annie</u>			MIDDLE <u>Loretta</u>	LAST <u>Strike</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>719 03 1377</u>		17. INFORMANT <u>Mildred E. Nye see # 13</u>			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			causative Heart Failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) <u>AS CVD</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)			DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED {ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2}		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on _____, 19_____, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I <input checked="" type="checkbox"/> did) <input type="checkbox"/> view the body after death.												
22b. SIGNATURE <u>Rose Marie Chan, M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8/19/84</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Rose Marie Chan</u>		22e. ADDRESS <u>Western Maryland Center, Hagerstown</u>		22f. LOCATION CITY OR TOWN <u>Williamsport, Md.</u>			22g. COUNTY	22h. STATE				
23a. BURIAL, CREMATION, REMOVAL SPECIFY <u>Burial</u>		23b. DATE <u>8-22-84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Mem. Pk.</u>		23d. LOCATION CITY OR TOWN <u>Williamsport, Md.</u>						
24. FUNERAL DIRECTOR NAME <u>Gerald N. Minnich</u>		25a. ADDRESS <u>305 N. Potomac St.</u>		25b. DATE REC'D. BY REGISTRAR <u>AUG 22 1984</u>		25c. REGISTRAR'S SIGNATURE <u>Dee Davidson Pendleton</u>						

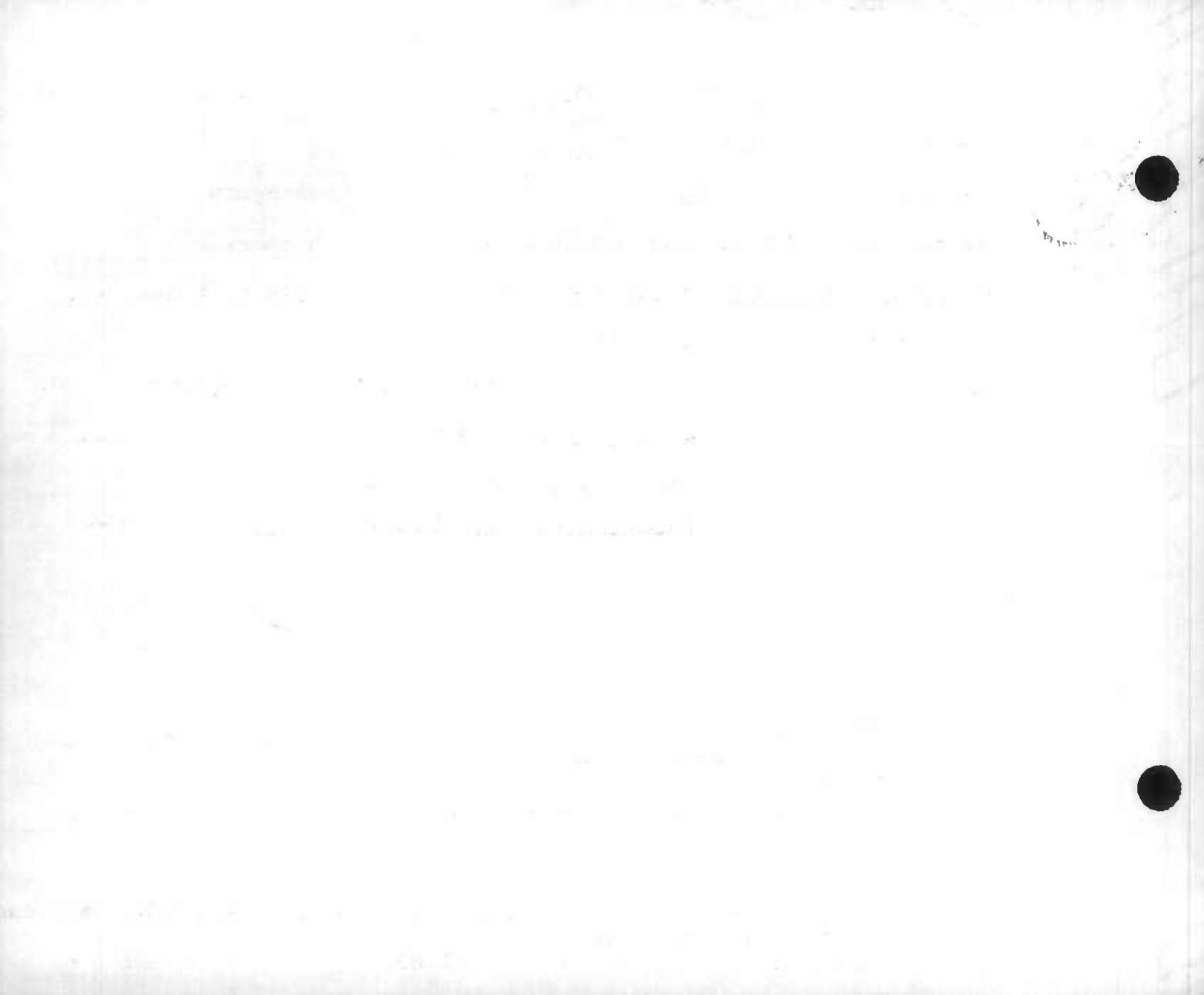


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1 - STATE REGISTRAR			REG. NO. 23112											
1. DECEASED NAME (TYPE OR PRINT)			FIRST <u>U. Wilson</u> MIDDLE <u>Adeline</u> LAST <u>Pappas</u>			2d. DATE OF DEATH MONTH <u>Aug 13</u> YEAR <u>84</u>			2b. HOUR <u>12 50 PM</u>					
3. SEX female			4. RACE white			5. DATE OF BIRTH MONTH <u>April</u> DAY <u>17</u> YEAR <u>1918</u>			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS <u>66</u> DAYS <u>YRS.</u>			IF UNDER 24 HRS HOURS <u>MIN.</u>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington			MD.		
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 325 N. Locust St. 21740		
14. FATHER'S NAME FIRST <u>Charles</u> MIDDLE <u></u> LAST <u>Carroll</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Amanda</u> MIDDLE <u></u> LAST <u></u>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT George C. Pappas, Hagerstown, Md.			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>			DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Hypoxic Defaction</u>			DUE TO, OR AS A CONSEQUENCE OF (c) <u>Interventricular Heart Disease</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. <u>19</u> MONTH <u></u> DAY <u></u> YEAR <u></u> P.M. <u></u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <u></u> CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u>								
22a. I certify that (I) (this hospital) attended the deceased from <u>8-13</u> 19 <u>84</u> , to <u>8-13</u> 19 <u>84</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>8-13</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.														
22b. SIGNATURE <u>George C. Pappas</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>8-13-84</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Aug. 16, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cem.			23d. LOCATION CITY OR TOWN Hagerstown , COUNTY Wash. , STATE Maryland					
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR Aug. 16, 1984			25b. REGISTRAR'S SIGNATURE Lidia Davidson-Pendell								
ADDRESS 415 E. Wilson Blvd., Hagerstown, Md.														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 2 and 3 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23113				
										REG. NO.				
1. DECEASED NAME FIRST MIDDLE LAST										2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
Vernon Leo Peacher										August 20, 1984				M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Male		White		November 10, 1913			70			MONTHS DAYS				
7a BIRTHPLACE STATE OR FOREIGN COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS				
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			WASHINGTON			HOURS MIN.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Hagerstown		Washington County Hospital								Assembler		Aircraft		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
Maryland		Washington		Hagerstown		67 Elizabeth St. 21740								
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME								
Charles		Augustus		Peacher		Anna								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
no				214-09-7211		Jeannette A. Peacher (item 13 above)								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>A lung - carcinoma of lung</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 months</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				CITY OR TOWN		COUNTY STATE				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET										
22a I certify that (I) (this hospital) attended the deceased from <i>December 1983</i> to <i>August 20, 1984</i> . That (I) <input checked="" type="checkbox"/> Host saw the deceased alive on <i>August 17, 1984</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (did not) view the body after death.										22c. DATE SIGNED <i>8-20-84</i>				
22b. SIGNATURE <i>John Thompson</i>		DEGREE								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOSEPH S. SECONDARI</i>		22e. ADDRESS <i>Boonsboro 21713</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION CITY OR TOWN		COUNTY STATE				
Burial		Aug. 23, 1984		Samples Manor Cem.				Samples Manor, Wash., Maryland						
24. FUNERAL DIRECTOR NAME		ADDRESS								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Major M. Osborne		Williamsport, MD 21795								AUG 24 1984		<i>S. John Davidson Pendee</i>		

10.05.1998

Georgina

01.1

10.05.1998



10.05.1998

Georgina

10.05.1998

10.05.1998

10.05.1998

10.05.1998

01.1

10.05.1998

10.05.1998

ETIS 2000

REGISTRO 4932T

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23114	
												REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			2b. HOUR	
			Lucille A. Pentz						8 7 84			1:00 P.M.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				
Female			Caucasian			MONTH 5 DAY 11 YEAR 1916			IF UNDER 1 YEAR 68 YRS.			IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Pennsylvania			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown			Washington County Hospital			receptionist			hospital				
13a. STATE			13b. COUNTY			13c. CITY QR TOWN			13d. INSIDE CITY LIMITS?				
Maryland			Washington			Maugansville			NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
FIRST Gilson MIDDLE E. LAST Fuse, Sr.			FIRST Evangeline MIDDLE Sheeley LAST										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			214-09-7427			Larry J. Pentz, Montgomery, Ala.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												months	
(b) <i>Abdominal Carcinomatosis</i>													
{ DUE TO, OR AS A CONSEQUENCE OF (b) <i>Clear cell Carcinoma of</i>													
DUE TO, OR AS A CONSEQUENCE OF (c)												415.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	
22a. I certify that (I) (this hospital) attended the deceased from 7/26 1984 to 8/1 1984, that (we) last saw the deceased alive on 8/1 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) (I did not) view the body after death.												STATE	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
Charles R. Chaney M.D.												8/3/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
Charles R. Chaney M.D.			363 S. Cleveland Ave Hagerstown										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY	
burial			Aug. 9, 1984			Rose Hill Cemetery			Hagerstown, Wash., Md.			STATE	
24. FUNERAL DIRECTOR NAME			MINNICH FUNERAL HOME ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
415 E. Wilson Blvd., Hagerstown, Md. 21740						AUG 10 1984			John Davidson Pendell				

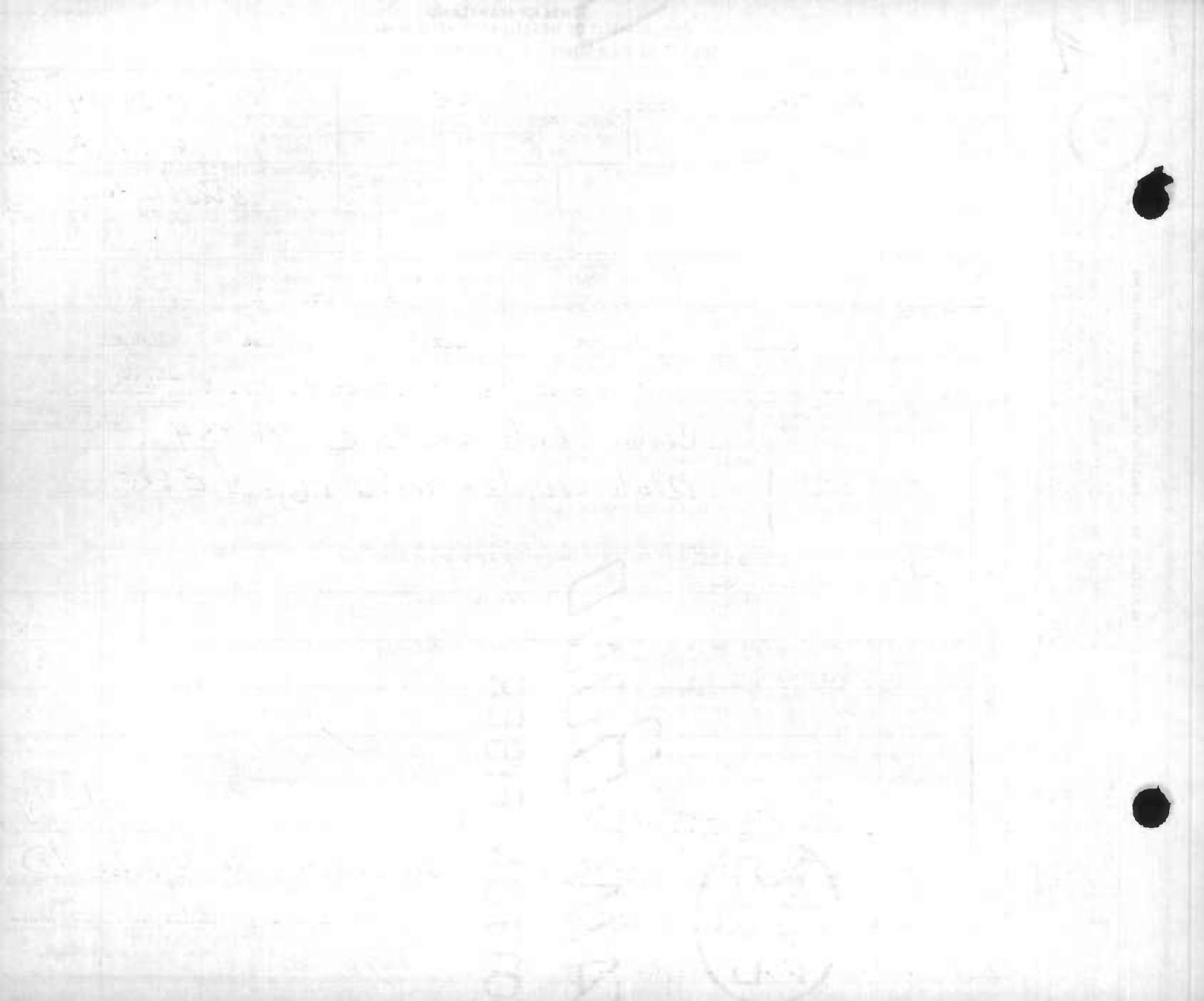
status is allowed

It is allowed to print

the following text

in the following way

2
7
4
10
14
18
22
26
30
34
38
42
46
50
54
58
62
66
70
74
78
82
86
90
94
98
102
106
110
114
118
122
126
130
134
138
142
146
150
154
158
162
166
170
174
178
182
186
190
194
198
202
206
210
214
218
222
226
230
234
238
242
246
250
254
258
262
266
270
274
278
282
286
290
294
298
302
306
310
314
318
322
326
330
334
338
342
346
350
354
358
362
366
370
374
378
382
386
390
394
398
402
406
410
414
418
422
426
430
434
438
442
446
450
454
458
462
466
470
474
478
482
486
490
494
498
502
506
510
514
518
522
526
530
534
538
542
546
550
554
558
562
566
570
574
578
582
586
590
594
598
602
606
610
614
618
622
626
630
634
638
642
646
650
654
658
662
666
670
674
678
682
686
690
694
698
702
706
710
714
718
722
726
730
734
738
742
746
750
754
758
762
766
770
774
778
782
786
790
794
798
802
806
810
814
818
822
826
830
834
838
842
846
850
854
858
862
866
870
874
878
882
886
890
894
898
902
906
910
914
918
922
926
930
934
938
942
946
950
954
958
962
966
970
974
978
982
986
990
994
998
1002
1006
1010
1014
1018
1022
1026
1030
1034
1038
1042
1046
1050
1054
1058
1062
1066
1070
1074
1078
1082
1086
1090
1094
1098
1102
1106
1110
1114
1118
1122
1126
1130
1134
1138
1142
1146
1150
1154
1158
1162
1166
1170
1174
1178
1182
1186
1190
1194
1198
1202
1206
1210
1214
1218
1222
1226
1230
1234
1238
1242
1246
1250
1254
1258
1262
1266
1270
1274
1278
1282
1286
1290
1294
1298
1302
1306
1310
1314
1318
1322
1326
1330
1334
1338
1342
1346
1350
1354
1358
1362
1366
1370
1374
1378
1382
1386
1390
1394
1398
1402
1406
1410
1414
1418
1422
1426
1430
1434
1438
1442
1446
1450
1454
1458
1462
1466
1470
1474
1478
1482
1486
1490
1494
1498
1502
1506
1510
1514
1518
1522
1526
1530
1534
1538
1542
1546
1550
1554
1558
1562
1566
1570
1574
1578
1582
1586
1590
1594
1598
1602
1606
1610
1614
1618
1622
1626
1630
1634
1638
1642
1646
1650
1654
1658
1662
1666
1670
1674
1678
1682
1686
1690
1694
1698
1702
1706
1710
1714
1718
1722
1726
1730
1734
1738
1742
1746
1750
1754
1758
1762
1766
1770
1774
1778
1782
1786
1790
1794
1798
1802
1806
1810
1814
1818
1822
1826
1830
1834
1838
1842
1846
1850
1854
1858
1862
1866
1870
1874
1878
1882
1886
1890
1894
1898
1902
1906
1910
1914
1918
1922
1926
1930
1934
1938
1942
1946
1950
1954
1958
1962
1966
1970
1974
1978
1982
1986
1990
1994
1998
2002
2006
2010
2014
2018
2022
2026
2030
2034
2038
2042
2046
2050
2054
2058
2062
2066
2070
2074
2078
2082
2086
2090
2094
2098
2102
2106
2110
2114
2118
2122
2126
2130
2134
2138
2142
2146
2150
2154
2158
2162
2166
2170
2174
2178
2182
2186
2190
2194
2198
2202
2206
2210
2214
2218
2222
2226
2230
2234
2238
2242
2246
2250
2254
2258
2262
2266
2270
2274
2278
2282
2286
2290
2294
2298
2302
2306
2310
2314
2318
2322
2326
2330
2334
2338
2342
2346
2350
2354
2358
2362
2366
2370
2374
2378
2382
2386
2390
2394
2398
2402
2406
2410
2414
2418
2422
2426
2430
2434
2438
2442
2446
2450
2454
2458
2462
2466
2470
2474
2478
2482
2486
2490
2494
2498
2502
2506
2510
2514
2518
2522
2526
2530
2534
2538
2542
2546
2550
2554
2558
2562
2566
2570
2574
2578
2582
2586
2590
2594
2598
2602
2606
2610
2614
2618
2622
2626
2630
2634
2638
2642
2646
2650
2654
2658
2662
2666
2670
2674
2678
2682
2686
2690
2694
2698
2702
2706
2710
2714
2718
2722
2726
2730
2734
2738
2742
2746
2750
2754
2758
2762
2766
2770
2774
2778
2782
2786
2790
2794
2798
2802
2806
2810
2814
2818
2822
2826
2830
2834
2838
2842
2846
2850
2854
2858
2862
2866
2870
2874
2878
2882
2886
2890
2894
2898
2902
2906
2910
2914
2918
2922
2926
2930
2934
2938
2942
2946
2950
2954
2958
2962
2966
2970
2974
2978
2982
2986
2990
2994
2998
3002
3006
3010
3014
3018
3022
3026
3030
3034
3038
3042
3046
3050
3054
3058
3062
3066
3070
3074
3078
3082
3086
3090
3094
3098
3102
3106
3110
3114
3118
3122
3126
3130
3134
3138
3142
3146
3150
3154
3158
3162
3166
3170
3174
3178
3182
3186
3190
3194
3198
3202
3206
3210
3214
3218
3222
3226
3230
3234
3238
3242
3246
3250
3254
3258
3262
3266
3270
3274
3278
3282
3286
3290
3294
3298
3302
3306
3310
3314
3318
3322
3326
3330
3334
3338
3342
3346
3350
3354
3358
3362
3366
3370
3374
3378
3382
3386
3390
3394
3398
3402
3406
3410
3414
3418
3422
3426
3430
3434
3438
3442
3446
3450
3454
3458
3462
3466
3470
3474
3478
3482
3486
3490
3494
3498
3502
3506
3510
3514
3518
3522
3526
3530
3534
3538
3542
3546
3550
3554
3558
3562
3566
3570
3574
3578
3582
3586
3590
3594
3598
3602
3606
3610
3614
3618
3622
3626
3630
3634
3638
3642
3646
3650
3654
3658
3662
3666
3670
3674
3678
3682
3686
3690
3694
3698
3702
3706
3710
3714
3718
3722
3726
3730
3734
3738
3742
3746
3750
3754
3758
3762
3766
3770
3774
3778
3782
3786
3790
3794
3798
3802
3806
3810
3814
3818
3822
3826
3830
3834
3838
3842
3846
3850
3854
3858
3862
3866
3870
3874
3878
3882
3886
3890
3894
3898
3902
3906
3910
3914
3918
3922
3926
3930
3934
3938
3942
3946
3950
3954
3958
3962
3966
3970
3974
3978
3982
3986
3990
3994
3998
4002
4006
4010
4014
4018
4022
4026
4030
4034
4038
4042
4046
4050
4054
4058
4062
4066
4070
4074
4078
4082
4086
4090
4094
4098
4102
4106
4110
4114
4118
4122
4126
4130
4134
4138
4142
4146
4150
4154
4158
4162
4166
4170
4174
4178
4182
4186
4190
4194
4198
4202
4206
4210
4214
4218
4222
4226
4230
4234
4238
4242
4246
4250
4254
4258
4262
4266
4270
4274
4278
4282
4286
4290
4294
4298
4302
4306
4310
4314
4318
4322
4326
4330
4334
4338
4342
4346
4350
4354
4358
4362
4366
4370
4374
4378
4382
4386
4390
4394
4398
4402
4406
4410
4414
4418
4422
4426
4430
4434
4438
4442
4446
4450
4454
4458
4462
4466
4470
4474
4478
4482
4486
4490
4494
4498
4502
4506
4510
4514
4518
4522
4526
4530
4534
4538
4542
4546
4550
4554
4558
4562
4566
4570
4574
4578
4582
4586
4590
4594
4598
4602
4606
4610
4614
4618
4622
4626
4630
4634
4638
4642
4646
4650
4654
4658
4662
4666
4670
4674
4678
4682
4686
4690
4694
4698
4702
4706
4710
4714
4718
4722
4726
4730
4734
4738
4742
4746
4750
4754
4758
4762
4766
4770
4774
4778
4782
4786
4790
4794
4798
4802
4806
4810
4814
4818
4822
4826
4830
4834
4838
4842
4846
4850
4854
4858
4862
4866
4870
4874
4878
4882
4886
4890
4894
4898
4902
4906
4910
4914
4918
4922
4926
4930
4934
4938
4942
4946
4950
4954
4958
4962
4966
4970
4974
4978
4982
4986
4990
4994
4998
5002
5006
5010
5014
5018
5022
5026
5030
5034
5038
5042
5046
5050
5054
5058
5062
5066
5070
5074
5078
5082
5086
5090
5094
5098
5102
5106
5110
5114
5118
5122
5126
5130
5134
5138
5142
5146
5150
5154
5158
5162
5166
5170
5174
5178
5182
5186
5190
5194
5198
5202
5206
5210
5214
5218
5222
5226
5230
5234
5238
5242
5246
5250
5254
5258
5262
5266
5270
5274
5278
5282
5286
5290
5294
5298
5302
5306
5310
5314
5318
5322
5326
5330
5334
5338
5342
5346
5350
5354
5358
5362
5366
5370
5374
5378
5382
5386
5390
5394
5398
5402
5406
5410
5414
5418
5422
5426
5430
5434
5438
5442
5446
5450
5454
5458
5462
5466
5470
5474
5478
5482
5486
5490
5494
5498
5502
5506
5510
5514
5518
5522
5526
5530
5534
5538
5542
5546
5550
5554
5558
5562
5566
5570
5574
5578
5582
5586
5590
5594
5598
5602
5606
5610
5614
5618
5622
5626
5630
5634
5638
5642
5646
5650
5654
5658
5662
5666
5670
5674
5678
5682
5686
5690
5694
5698
5702
5706
5710
5714
5718
5722
5726
5730
5734
5738
5742
5746
5750
5754
5758
5762
5766
5770
5774
5778
5782
5786
5790
5794
5798
5802
5806
5810
5814
5818
5822
5826
5830
5834
5838
5842
5846
5850
5854
5858
5862
5866
5870
5874
5878
5882
5886
5890
5894
5898
5902
5906
5910
5914
5918
5922
5926
5930
5934
5938
5942
5946
5950
5954
5958
5962
5966
5970
5974
5978
5982
5986
5990
5994
5998
6002
6006
6010
6014
6018
6022
6026
6030
6034
6038
6042
6046
6050
6054
6058
6062
6066
6070
6074
6078
6082
6086
6090
6094
6098
6102
6106
6110
6114
6118
6122
6126
6130
6134
6138
6142
6146
6150
6154
6158
6162
6166
6170
6174
6178
6182
6186
6190
6194
6198
6202
6206
6210
6214
6218
6222
6226
6230
6234
6238
6242
6246
6250
6254
6258
6262
6266
6270
6274
6278
6282
6286
6290
6294
6298
6302
6306
6310
6314
6318
6322
6326
6330
6334
6338
6342
6346
6350
6354
6358
6362
6366
6370
6374
6378
6382
6386
6390
6394
6398
6402
6406
6410
6414
6418
6422
6426
6430
6434
6438
6442
6446
6450
6454
6458
6462
6466
6470
6474
6478
6482
6486
6490
6494
6498
6502
6506
6510
6514
6518
6522
6526
6530
6534
6538
6542
6546
6550
6554
6558
6562
6566
6570
6574
6578
6582
6586
6590
6594
6598
6602
6606
6610
6614
6618
6622
6626
6630
6634
6638
6642
6646
6650
6654
6658
6662
6666
6670
6674
6678
6682
6686
6690
6694
6698
6702
6706
6710
6714
6718
6722
6726
6730
6734
6738
6742
6746
6750
6754
6758
6762
6766
6770
6774
6778
6782
6786
6790
6794
6798
6802
6806
6810
6814
6818
6822
6826
6830
6834
6838
6842
6846
6850
6854
6858
6862
6866
6870
6874
6878
6882
6886
6890
6894
6898
6902
6906
6910
6914
6918
6922
6926
6930
6934
6938
6942
6946
6950
6954
6958
6962
6966
6970
6974
6978
6982
6986
6990
6994
6998
7002
7006
7010
7014
7018
7022
7026
7030
7034
7038
7042
7046
7050
7054
7058
7062
7066
7070
7074
7078
7082
7086
7090
7094
7098
7102
7106
7110
7114
7118
7122
7126
7130
7134
7138
7142
7146
7150
7154
7158
7162
7166
7170
7174
7178
7182
7186
7190
7194
7198
7202
7206
7210
7214
7218
7222
7226
7230
7234
7238
7242
7246
7250
7254
7258
7262
7266
7270
7274
7278
7282
7286
7290
7294
7298
7302
7306
7310
7314
7318
7322
7326
7330
7334
7338
7342
7346
7350
7354
7358
7362
7366
7370
7374
7378
7382
7386
7390
7394
7398
7402
7406
7410
7414
7418
7422
7426
7430
7434
7438
7442
7446
7450
7454
7458
7462
7466
7470
7474
7478
7482
7486
7490
7494
7498
7502
7506
7510
7514
7518
7522
7526
7530
7534
7538
7542
7546
7550
7554
7558
7562
7566
7570
7574
7578
7582
7586
7590
7594
7598
7602
7606
7610
7614
7618
7622
7626
7630
7634
7638
7642
7646
7650
7654
7658
7662
7666
7670
7674
7678
7682
7686
7690
7694
7698
7702
7706
7710
7714
7718
7722
7726
7730
7734
7738
7742
7746
7750
7754
7758
7762
7766
7770
7774
7778
7782
7786
7790
7794
7798
7802
7806
7810
7814
7818
7822
7826
7830
7834
7838
7842
7846
7850
7854
7858
7862
7866
7870
7874
7878
7882
7886
7890
7894
7898
7902
7906
7910
7914
7918
7922
7926
7930
7934
7938
7942
7946
7950
7954
7958
7962
7966
7970
7974
7978
7982
7986
7990
7994
7998
8002
8006
8010
8014
8018
8022
8026
8030
8034
8038
8042
8046
8050
8054
8058
8062
8066
8070
8074
8078
8082
8086
8090
8094
8098
8102
8106
8110
8114
8118
8122
8126
8130
8134
8138
8142
8146
8150
8154
8158
8162
8166
8170
8174
8178
8182
8186
8190
8194
8198
8202
8206
8210
8214
8218
8222
8226
8230
8234
8238
8242
8246
8250
8254
8258
8262
8266
8270
8274
8278
8282
8286
8290
8294
8298
8302
8306
8310
8314
8318
8322
8326
8330
8334
8338
8342
8346
8350
8354
8358
8362
8366
8370
8374
8378
83

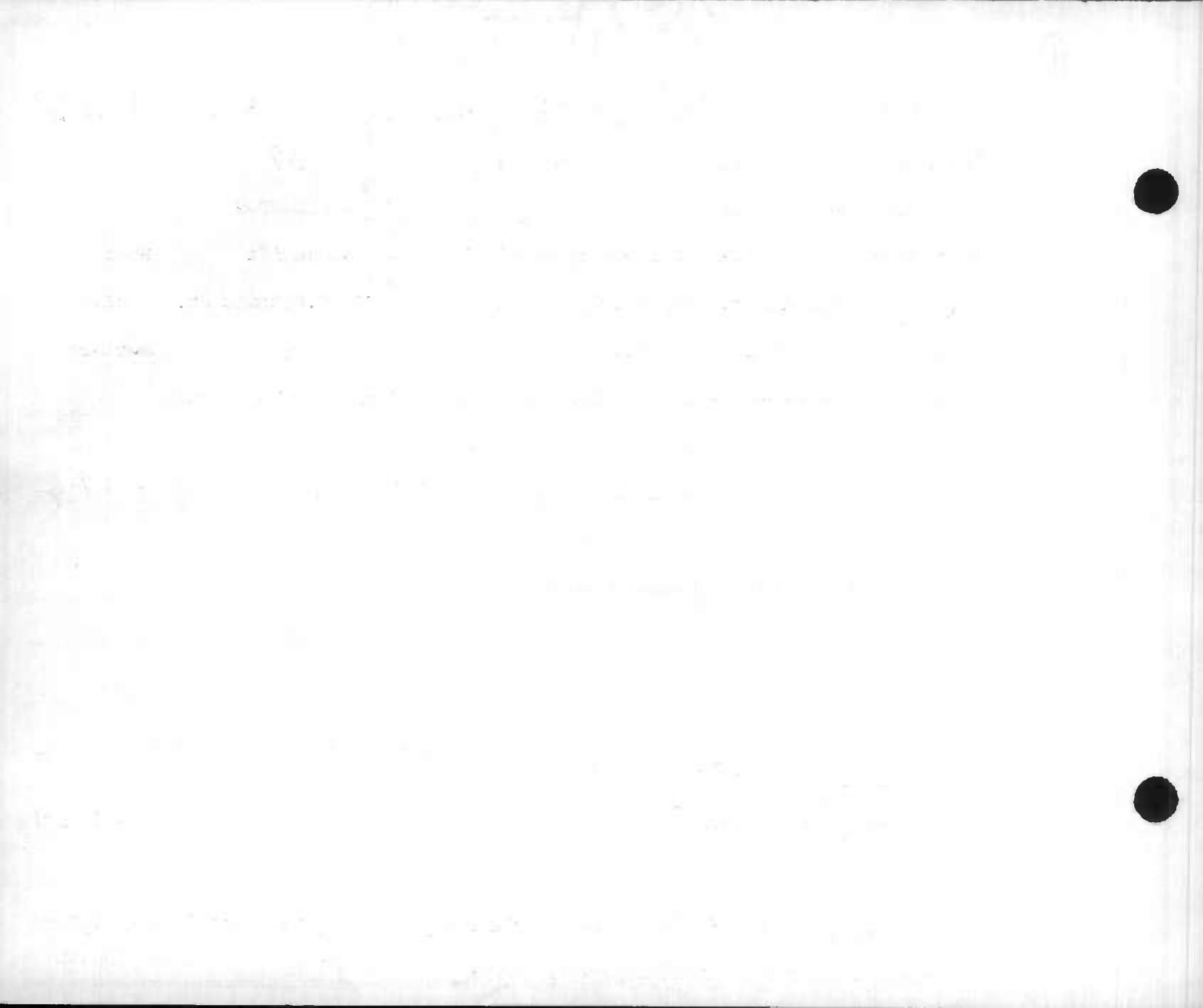


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23116				
										REG. NO.				
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			MIDDLE	LAST	2d. DATE OF DEATH		MONTH	DAY	YEAR	2d. HOUR	
			Cleo			May	Poffenberger	8 22 84					11 20 PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
female			white			MONTH	DAY	YEAR	69			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 72 HRS.		
Maryland			USA						WASHINGTON			MONTHS HOURS MIN.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.		
Hagerstown			Washington County Hospital			Housewife			Home					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland			Washington			Hagerstown						751 S. Potomac St. 21740		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
			Ray	Edward	Smith	Lilia			May		Lawrence			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
no			220-34-1179			Glenwood Poffenberger-Funkstown, MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) Cardiogenic shock										24 hours				
DUE TO, OR AS A CONSEQUENCE OF (b) Aunt inferior with myocardial infarct 7 days														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 8-16-1984 to 8-22-1984, that (I/we) last saw the deceased alive on 8-22-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>Dr. H. J. Harlan</i>										DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8-23-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Aug. 25, 1984			23c. NAME OF CEMETERY OR CREMATORIUM Fairview Cemetery			23d. LOCATION CITY OR TOWN Keedysville			COUNTY Washington	STATE Maryland	
Burial														
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Major M. Osborne			Williamsport, MD 21795			AUG 28 1984			<i>John Davidson-Randall</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon/paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23117			
1. FOR STATE REGISTRAR LEONARD EARL PRICE			2a. DATE OF DEATH 8 17 84							MONTH DAY YEAR		2b. HOUR 9:20 AM	
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			S. DATE OF BIRTH MONTH 01 DAY 23 YEAR 03				6. AGE (IN YEARS LAST BIRTHDAY) 81		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
3. SEX Male			4. RACE Caucas			7. DATE OF BIRTH				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Virginia			7b. CITIZEN OF WHAT COUNTRY USA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cotton Villa NURSING CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Home Improv.	
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cotton Villa NURSING CENTER			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 1020 Murdock Avenue 21740			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Martz										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-09-0523			17. INFORMANT Genevieve A. Price			ADDRESS 1020 Murdock Avenue Hagerstown, Md. 21740				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia & Diphilus mediob (c) organic brain syndrome										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/18/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			1600 Park Hill Ave. HAG. MD 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-20-84			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Washington, Md.				
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown			ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG. 22 1984			25b. REGISTRAR'S SIGNATURE Julie Sander-Randall				
DHMH - 16 50M 4/83 (VRA 15, 4)													

COLIN DAVIS GREGORY

1583

RECEIVED ON BEHALF OF THE GOVERNMENT

RECEIVED

RECEIVED ON BEHALF OF THE GOVERNMENT

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23118			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Raymond R. Pryor					Pryor	8/10/84						3:45 AM			
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
m			w	JAN. 31 1889			95			YEARS			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Foxville Md			American						Washington MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Williamsport			Williamsport Nursing Home			Labor			Dairy						
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21795			
Md.			Washington			Williamsport			154 N. Artizan St.						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME									
			Alfred		Pryor	Marietta									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			184-26-2874			Mr. Clarence Blubaugh 223 Landis Ave.			Waynesboro, Pa. 17268						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b1, and 1c1) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 8/10/84			
22b. SIGNATURE John R. Melnick ad			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Melnick			22e. ADDRESS 16220 Frederick R. Gaithersburg, Md. 20760												
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 8/12/84			23c. NAME OF CEMETERY OR CREMATORIAL Green Hill Cemetery			23d. LOCATION CITY OR TOWN Waynesboro			COUNTY	STATE		
24. FUNERAL DIRECTOR Madie Cope			50 S. Broad St. Waynesboro, Pa. 17268			25a. DATE REC'D. BY REGISTRAR 17268 AUG 13 1984			25b. REGISTRAR SIGNATURE John Davidson - Franklin Pa.						



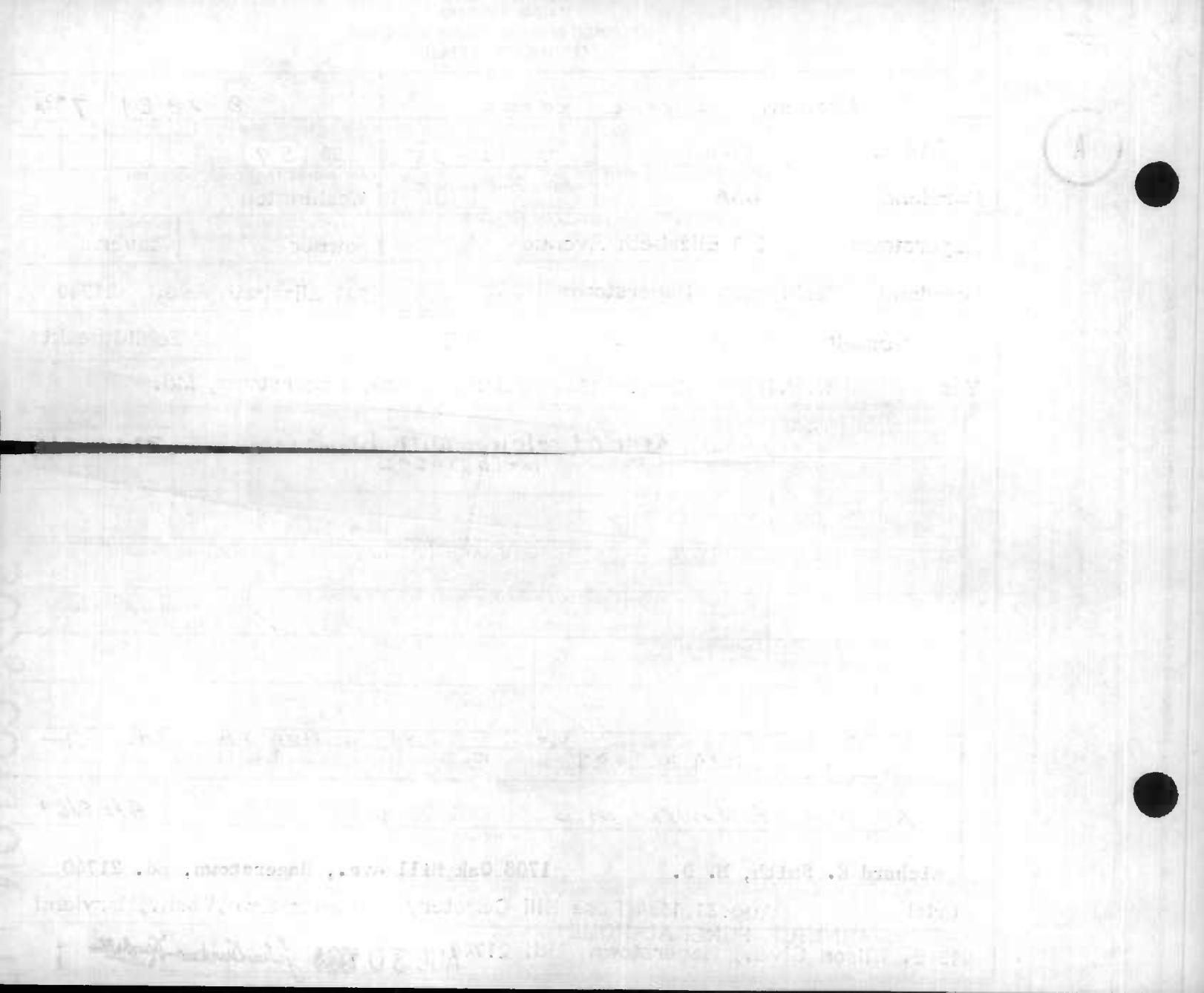
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do so.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23113			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST		8-28-84			2b. HOUR 7:45 A.M.		
Norman Eugene Reese													
3. SEX Male			4 RACE cau.			5. DATE OF BIRTH MONTH DAY YEAR 7-12-26		6. AGE (IN YEARS LAST BIRTHDAY) 58			IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington			IF UNDER 24 HRS HOURS MIN.		
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 301 Elizabeth Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) owner			12b. KIND OF BUSINESS OR INDUSTRY tavern				
13a. STATE Maryland			13b. COUNTY Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 301 Elizabeth Ave. 21740					
14. FATHER'S NAME FIRST MIDDLE LAST Russell Edgar Reese			15. MOTHER'S MAIDEN NAME Julia			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>			16b. SOCIAL SECURITY NO. W.W.II 220-18-1452				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of colon with hepatic metastases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									ADDRESS Delores Reese, Hagerstown, Md.				
									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hours				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Dec 19 81 to Aug 28 1984, that (I) (we) lost saw the deceased live an 14 Aug 14 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE Richard E. Smith, M.D.			DEGREE						22c. DATE SIGNED 8/28/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Smith, M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 1708 Oak Hill Ave., Hagerstown, Md. 21740							
23a. BURIAL, CREMATION, REMOVAL burial			23b. DATE Aug. 31, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland COUNTY STATE				
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME 415 N.E. Wilson Blvd., Hagerstown, Md. 21740						25a. DATE REC'D. BY REGISTRAR AUG 30 1984			25b. REGISTRAR'S SIGNATURE John Davidson				



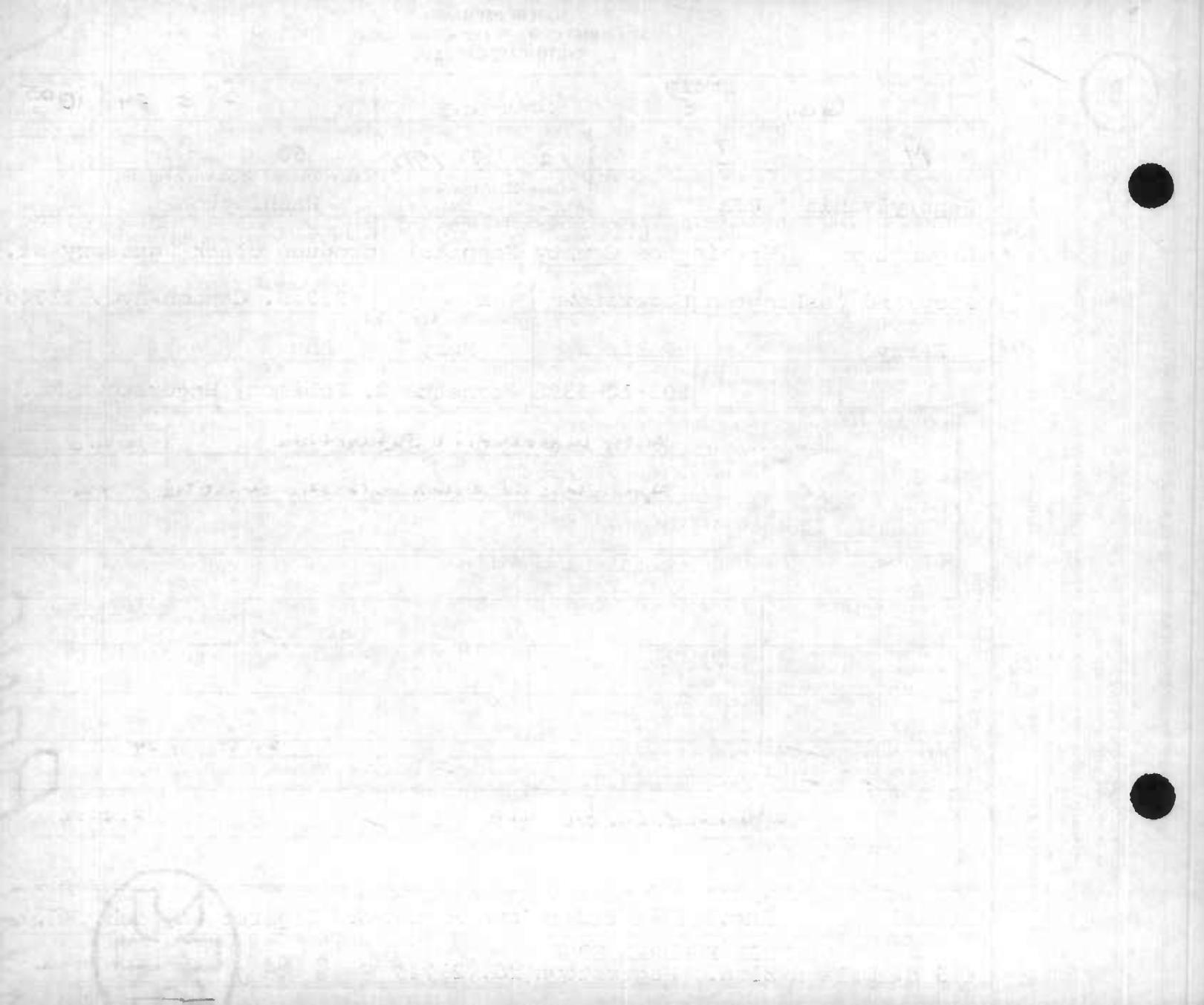
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use as the burial-memorandum permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23120									
										REG. NO.									
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)			FIRST Emory		MIDDLE E		LAST Robison		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
		<i>Guy</i>									8 5 84				10:05	P.M.			
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
<i>M</i>		<i>C</i>			MONTH 12 DAY 9 YEAR 1915			68			MONTHS	DAYS	HOURS	MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Pennsylvania		USA						Washington											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Hagerstown		Washington County Hospital			produce clerk			grocery st.											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE		13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE								
Maryland		Washington			Hagerstown						363 S. Cannon Ave. 21740								
14. FATHER'S NAME FIRST Harry		MIDDLE			LAST Robison			15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE		LAST Ann						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			16c. ADDRESS			17. INFORMANT											
(If Yes, give war or dates)		203-10-6386						Jeanette D. Robison, Hagerstown, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
<i>acute myocardial Infarction</i>										10 min									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) } DUE TO, OR AS A CONSEQUENCE OF { DUE TO, OR AS A CONSEQUENCE OF (c) } <i>My previous Arteriosclerotic Heart Dis.</i>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE						
22a. I certify that (I) (the hospital) attended the deceased from _____ 19_____, to _____ 8-5-84_____, 19_____, that (I) (we) lost saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <i>Jeanette D. Robison</i>										DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-5-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL SPECIALTY burial		23b. DATE Aug. 8, 1984			23c. NAME OF CEMETERY OR CREMATORIAL HOME Cedar Lawn Mem. Park			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Md.											
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740								25a. DATE REC'D. BY REGISTRAR AUG 9 1984			25b. REGISTRAR'S SIGNATURE <i>Julie Davidson Pendell</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 is checked, any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23121	
												REG. NO.	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			<i>Margaret Elizabeth Lowe</i>						<i>8/30/84</i>			<i>11:09 AM</i>	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
<i>female</i>		<i>white</i>		<i>4 15 100</i>			<i>84</i>			<i>YRS.</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. MD.			
<i>West Virginia</i>		<i>USA</i>					<i>Washington</i>						
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
<i>Hagerstown</i>		<i>Avalon Manor Nursing Home</i>		<i>housewife</i>			<i>Route 10, Box 3</i>			<i>21740</i>			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
<i>Maryland</i>		<i>Washington</i>		<i>Hagerstown</i>									
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
<i>Martin</i>		<i>Fuss</i>			<i>Rebecca</i>						<i>Fuss</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
<i>No</i>		<i>212-74-4268</i>		<i>Sandra Sherman, Severn, Md.</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerosis</i>												years	
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						<input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) attended the deceased from <i>11/12/79</i> 19 to <i>8/30/84</i> 19, that (I) lost saw the deceased alive on <i>8/22/84</i> 19, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) did not see the body after death.												22c. DATE SIGNED <i>8/30/84</i>	
22b. SIGNATURE <i>Howard N. Weeks</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Howard N. Weeks, M.D.</i>			22e. ADDRESS <i>580 Northern Ave., Hagerstown, Md. 21740</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>			23b. DATE <i>Sept. 1, 1984</i>			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Rest Haven Cem.</i>			23d. LOCATION CITY OR TOWN <i>Hagerstown, Wash., Md.</i>				
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>			25a. DATE REC'D. BY REGISTRAR <i>21740</i>			25b. REGISTRAR'S SIGNATURE <i>Linda R. Pendleton</i>							



B
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23122			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR	
ANNABELLE F. SCOTT							8 / 30 / 84						1984	4:20 M	
3. SEX		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		Month Day Year July 9, 1896			88				MONTHS	DAYS	HOURS	MIN.	
YRS.															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				MD.				
Martinsburg, W. Va.		U. S. A.					Washington								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Ravenwood Lutheran Nursing Home			Housewife			Own Home							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		21211					
Maryland		Baltimore		Baltimore				1206 Cox St.							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST						
		Oliver	Nelson	Anderson			Annie	Elizabeth	Price						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT		ADDRESS								
No		214-30-3043			Mrs. Frances Norris, Boonsboro, Md. 21713		Rfd. 1 Bpx 279								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Min 47 - 6			
(b) <i>Pneumonia</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVD</i>												yes			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED AT WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>19-82</i> to <i>8-79</i> on <i>19-82</i> , that (I) (we) last saw the deceased alive on <i>8-29</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												19 <i>82</i> to <i>8-79</i> 19 <i>82</i>			
22b. SIGNATURE <i>Sealy MD</i>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>8-31-84</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. J. Sealy MD</i>		22e. ADDRESS <i>1933 Va Ave, Hagerstown, Md.</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-4 - 84		23c. NAME OF CEMETERY OR CREMATORIAL Poplar Grove Cemetery			23d. LOCATION CITY OR TOWN Warren,		COUNTY Baltimore,		STATE Md.				
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.		ADDRESS Boonsboro, Maryland 21713			25a. DATE REC'D. BY REGISTRAR SEP 6 1984		25b. REGISTRAR'S SIGNATURE <i>John H. Bast, Jr.</i>								

George Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3) should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23123

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d. HOUR			
<i>Margaret ELIZABETH Shives</i>						8	4	84	12 PM	31			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
FEMALE		WHITE		MONTH	DAY	YEAR	65 YRS.			IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS				
WEST VIRGINIA		UNITED STATES		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>Washington</i>			HOURS MIN.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN		WASHINGTON COUNTY HOSPITAL					HOMEMAKER			MD.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
MARYLAND		WASHINGTON		CLEARSPRING		XX		Rt. 1 BOX 196			21722		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST				
		EDWIN		BURKE	MATTIE				SPRING				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO				212 82 9044		MR. HARRY A. SHIVES		SAME AS 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pseudomonus sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Complications of surgery, repair thoracic aortic aneurysm</i>													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Thoracic aortic aneurysm, cocaine abuse disease, temporal arteritis</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY?		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) this hospital attended the deceased from <i>7/8</i> , 19 <i>84</i> , to <i>8/4</i> , 19 <i>84</i> , that (we) last saw the deceased alive on <i>7/3</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE <i>Allen W. Dix, MD</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>8/4/84</i>							
22e. ADDRESS <i>1610 Oak Hill Ave. Hagerstown MD 21740</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>08/07/1984</i>		23c. NAME OF CEMETERY OR CREMATORIAL ST. PETERS CATHOLIC		23d. LOCATION CITY OR TOWN <i>HANCOCK, WASHINGTON, MD. 21750</i>							
24. FUNERAL DIRECTOR <i>Kathleen Deale Hancock Mo.</i>		25a. ADDRESS <i>Kathleen Deale Hancock Mo.</i>		25b. DATE REC'D. BY REGISTRAR <i>AUG 9 1984</i>		25c. REGISTRAR'S SIGNATURE <i>Julie Davidson Pendell</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

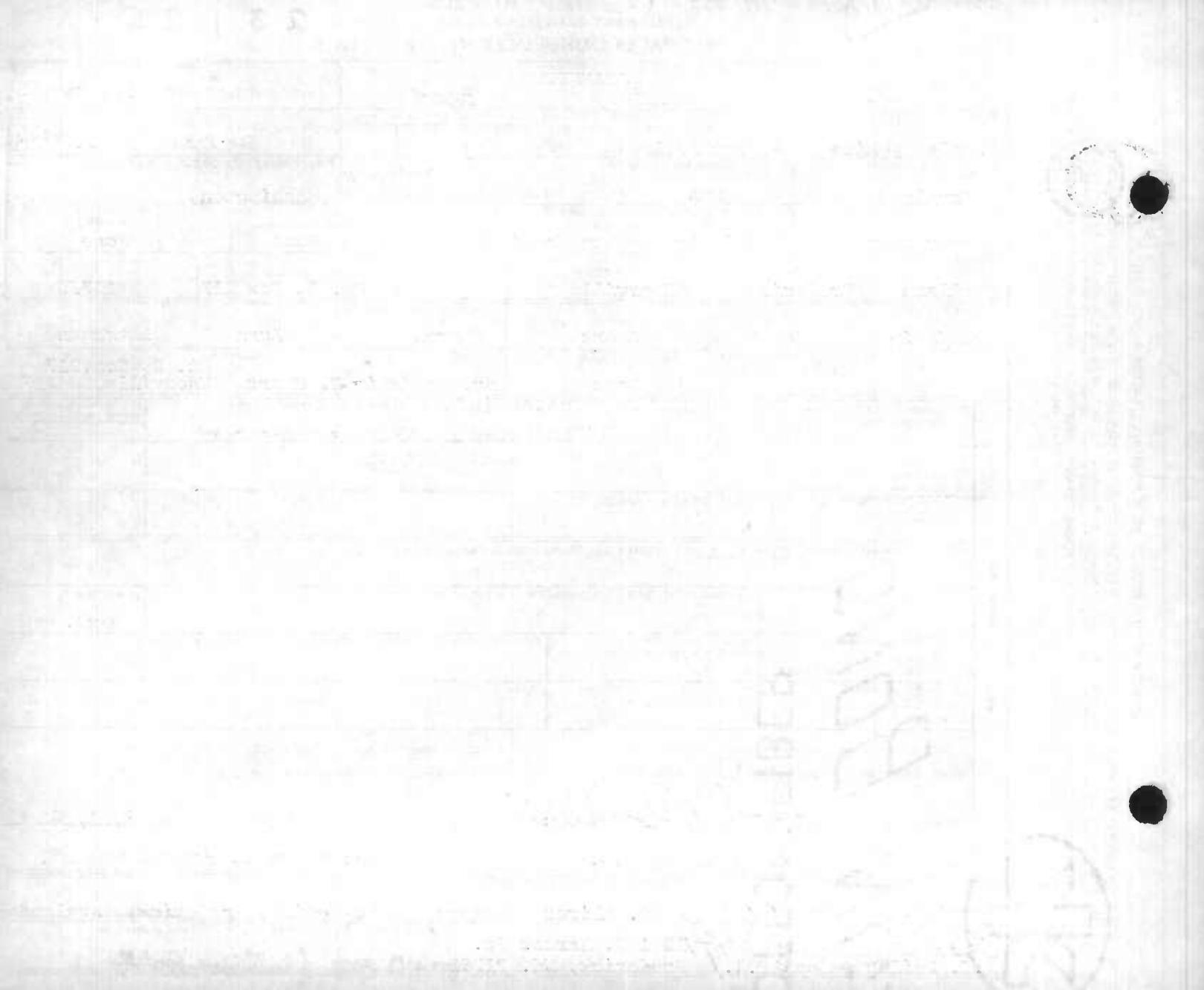
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. <i>23124</i>												
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		2b. HOUR	
<i>Esther C Siler</i>									<i>August 23, 1984</i>		<i>1240am</i>	
3. SEX			4. RACE				5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			
<i>female</i>			<i>white</i>				<i>May 13, 1913</i>		71		<i>IF UNDER 1 YEAR MONTHS DAYS</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WV.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington County</i>		<i>MD.</i>	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a. SHOE OWNER (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>shoes</i>			
13a. STATE <i>Md.</i>			13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1401 Haven Rd. Apt. 11</i>			
14. FATHER'S NAME			FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME			
<i>Russell</i>							<i>Evans</i>		<i>FIRST</i>	<i>E.</i>	<i>Middle</i>	<i>LAST</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.				17. INFORMANT			ADDRESS		
<i>no</i>							<i>Jane Morriss</i>			<i>116 S. Maple WV.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>GERM RENAL CANCER</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>RECURRENT LIPOPID CRU CANCER</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>RECURRENT LIPOPID CRU CANCER</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>REBURE FAILURE, HYPERTENSION BSCVD</i>												
19a. DATE OF OPERATION <i>Aug 1983</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>BURIGH LIPOPID CRU THER</i>					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>8.22</i>		21f. LOCATION STREET <i>100 Long Meadow Drive Martinsburg, WV.</i>		CITY OR TOWN <i>75</i>		COUNTY <i>8.23</i>		STATE <i>84</i>	
22a. I certify that (I) this hospital attended the deceased from <i>8.22</i> to <i>8.23</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Ottie R. Siler</i>			22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>8.23.84</i>					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ottie R. Siler MD</i>			22g. ADDRESS <i>100 Long Meadow Drive Martinsburg, WV.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>8/25/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rosedale Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Martinsburg, Berkeley</i>		COUNTY		STATE	
24. FUNERAL DIRECTOR <i>John C. Siler</i>			24b. ADDRESS <i>815 W. King Str. Martinsburg, WV.</i>		24c. DATE REC'D. BY REGISTRAR <i>AUG 29 1984</i>		24d. REGISTRAR'S SIGNATURE <i>Julie Henderson Pendelle</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN 1 PAGE 5 AND YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										23125		
														REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR		7b. HOUR								
ISLA		JEANNETTE SMART SMART		<input checked="" type="checkbox"/>		Aug. 30, 1984		5:55 PM								
2. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		7d. HOUR		
Female		White		August 16, 1984		YRS.		15		Aug. 30, 1984		6:55 pm				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		<input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA								Washington,						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY										
Hagerstown		Washington County Hospital		None		None										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS								
Maryland		Frederick		Knoxville		Rt. 2, Box 217		21758								
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
Benjamin		Sharon		Homer		(IF YES, GIVE WAR OR DATES)		None		Mr. Benjamin H. Smart		Rt. 2, Box. 217 Knoxville, Md 21758				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:		Sudden infant death syndrome										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a)		Pending complete autopsy report and further investigation														
DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																
{ (b)		DUE TO, OR AS A CONSEQUENCE OF														
{ (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY?				
												<input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE		TITLE (SPECIFY) Howard N. Weeks, M.D.										DATE SIGNED 8/31/84				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 580 Northern Ave., Hagerstown, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9/4/84		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN Frederick		COUNTY Frederick		STATE Maryland						
Burial																
24. FUNERAL DIRECTOR R.E. Dailey & Son, P.A.		1201 N. Market St.		1201 N. Market St.		75a. DATE REC'D. BY REGISTRAR		75b. REGISTRAR'S SIGNATURE								
BP 871																
DHMH - 17 (VR A15 ME (5))																
20M 4/82																



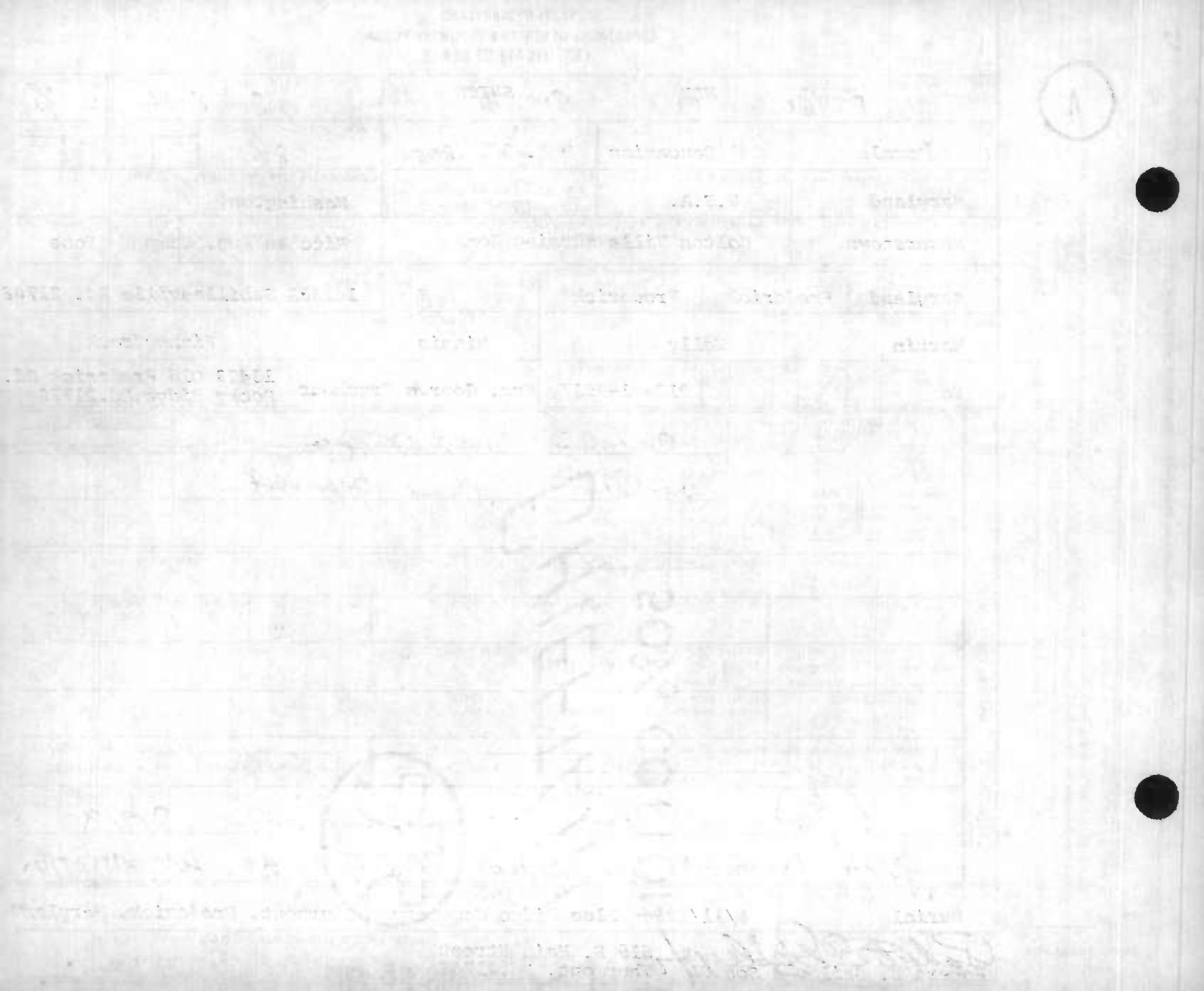
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, it must be noted above.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23120			
1. FOR STATE REGISTRAR		1. DECEASED NAME FIRST ETHEL ETHEL				MIDDLE MAY		LAST SMITH		2a. DATE OF DEATH 8 - 8 - 84		2b. HOUR 12 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Month Feb Day 26 Year 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 yrs		7. IF UNDER 1 YEAR MONTHS		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington, MD.							
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Corton Villa Nursing Home		12a. USUAL OCCUPATION Kitchen Emp. Camp		12b. KIND OF BUSINESS OR INDUSTRY None							
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 14838A Sabillasville Rd. 21788					
14. FATHER'S NAME FIRST Martin		MIDDLE Kelly		LAST		15. MOTHER'S MAIDEN NAME Minnie		MIDDLE		LAST Finneyfrack			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-01-9017		17. INFORMANT Mrs. George Frushour		ADDRESS 13423 Old Frederick Rd. Rocky Ridge, Md. 21778							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coughing Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Atrial fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____ 19 _____, to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												22c. DATE SIGNED 8/8/84	
22b. SIGNATURE J. D. Baileys, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ashton W. Baileys, M.D.		22e. ADDRESS 1600 Oak Hill Ave. Hagerstown, Maryland 21740											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/11/1984		23c. NAME OF CEMETERY OR CREMATORIAL Blue Ridge Cemetery		23d. LOCATION CITY OR TOWN Thurmont, Frederick, Maryland		23e. COUNTY Frederick		23f. STATE Maryland			
24. FUNERAL DIRECTOR Robert E. Baileys & Son, P.A.		25a. 615 E. Main Street Thurmont, Md. 21788		25b. DATE REC'D. BY REGISTRAR 8/15/1984		25c. REGISTRAR'S SIGNATURE Sylvia Kainan Rendell							

A

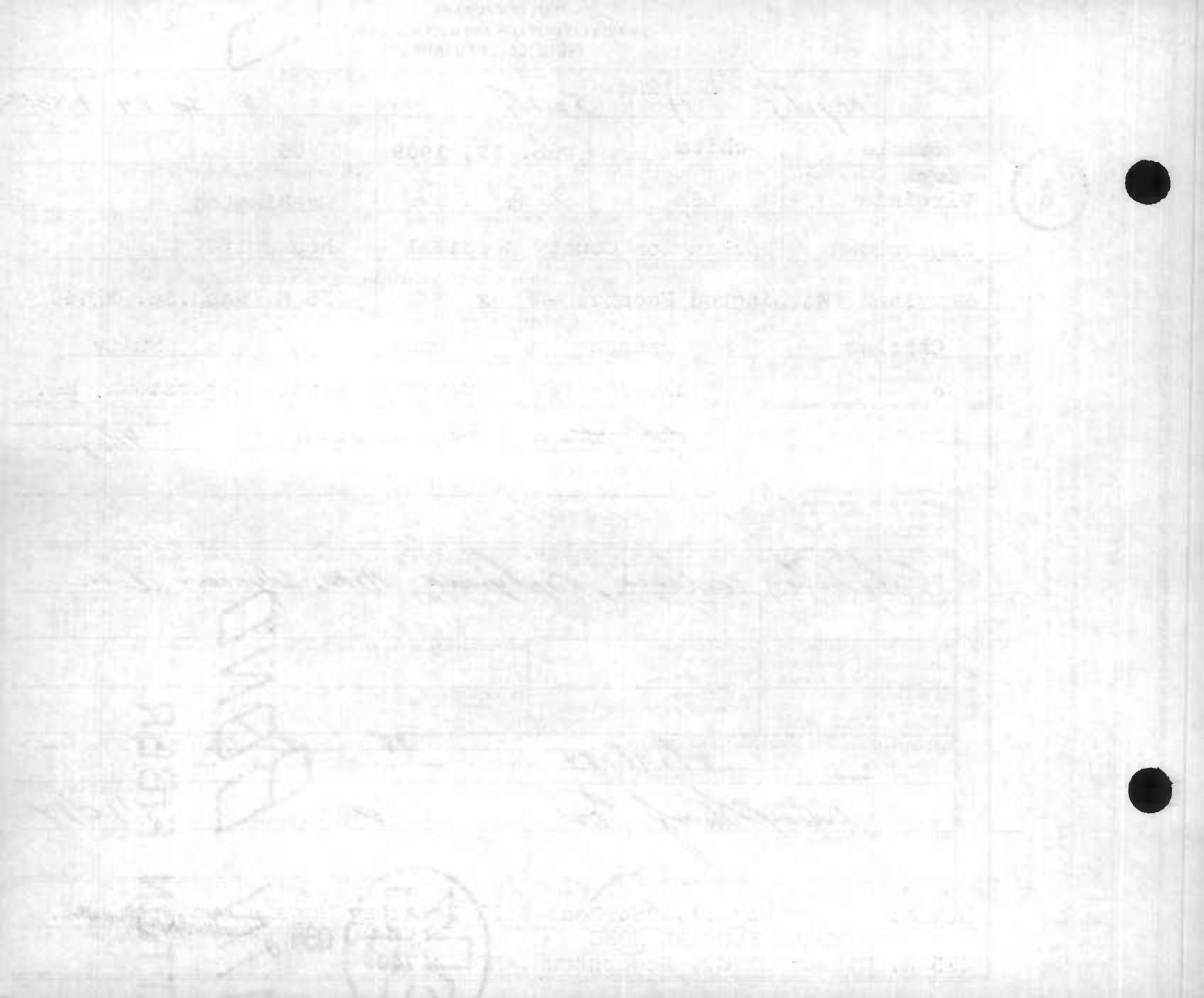


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "Died at home", the medical examiner will not be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23121			
												REG. NO.			
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			<i>Mystle Adeline Smith</i>						8 30 84			1:50 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
female		white		Feb. 17, 1909			75			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Virginia		USA					Washington								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital										housewife			
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Maryland Washington Hagerstown												YES <input checked="" type="checkbox"/>		55 E. Wash. St. 21740	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Charles Benson			Nora Nulty												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			214-09-9666			Beverly J. Davis, Hagerstown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>left lower lobe pneumonia</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Polyuria, anemia, emphysema, 8500, edema skin</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>19 28</u> , to <u>8 30</u> , 19 <u>84</u> , that (I) (was last saw the deceased alive on <u>8 29 19 84</u> , and that in (my) (ent) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death)															
22b. SIGNATURE <i>Edward B. Thurz Jr.</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>8/30/84</i>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Sept. 1, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash. Md.						
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			ADDRESS <i>BEPTO 1000</i>												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23128	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Ralph Dennis Strevig			Ralph	D.	STREVIG	August 21, 1984					8 43 PM		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			White		MONTH June DAY 12, YEAR 1894		90			MONTHS	DAYS	HOURS	MIN.
7b. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			Washington County MD.			
Maryland			U.S.A.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			Avalon Manor Nursing Home		Advertising Manager Dept. Store								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												21740	
13c. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
Maryland			Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			849 Mulberry Avenue			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	Gettier			
Theodore			R.	Strevig	Susan								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Yes			WW I		Elsie M. Strevig 849 Mulberry Avenue			Hagerstown, Md. 21740				5 minutes	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <u>Frailty</u> , <u>Alzheimer's Disease with Dementia</u> + 20 years													
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 19</u> 19 <u>84</u> to <u>Aug 19</u> 19 <u>84</u> , that (I/we) last saw the deceased alive on <u>Aug 19</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.													
22b. SIGNATURE <u>Robert Brull</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>8/21/84</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert Brull</u>			22e. ADDRESS 1459 Potomac Ave.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Washington, Md.			25a. DATE REC'D. BY REGISTRAR AUG 27 1984			25b. REGISTRAR'S SIGNATURE <u>Sylvia Davidson-Pendell</u>	
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md.			ADDRESS										

TO THE CHIEF LIBRARIAN



B

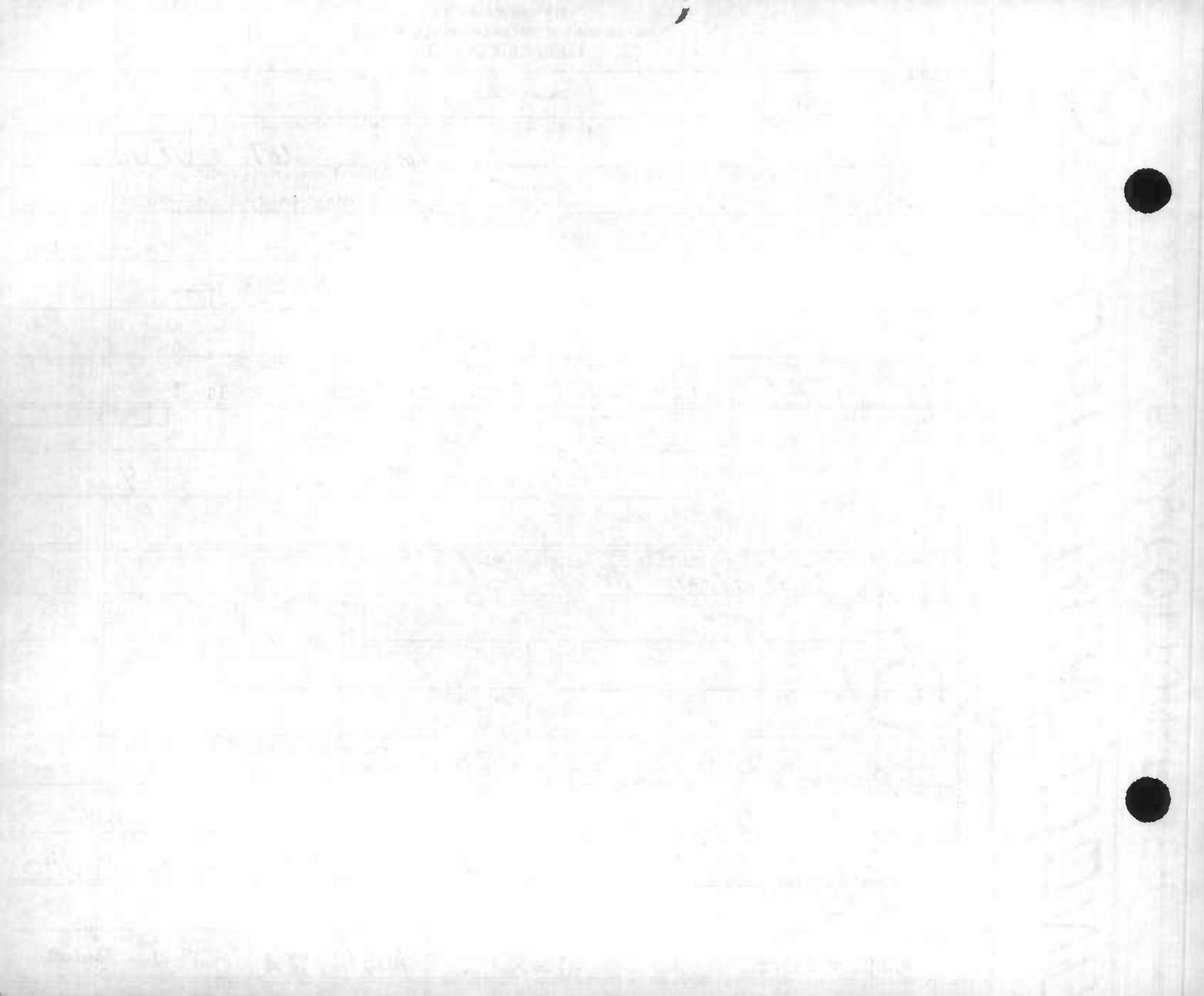
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 showing any injury, or other traumatic event, the medical examiner may be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23129			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
<i>Allen</i>					<i>Strunk</i>	8			1	84		11 AM			
3. SEX			4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
<i>m</i>			<i>w</i>	MONTH	DAY	YEAR	8 20 16			MONTHS	YEARS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			
<i>Pennsylvania</i>			<i>U.S.</i>						<i>Washington County</i>			<i>Boonsboro</i>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE		13b. COUNTY		13c. CITY OR TOWN		
<i>Route 1, Box 398</i>			<i>Plumber</i>			<i>Construction</i>			<i>Md.</i>		<i>WASH</i>		<i>Boonsboro</i>		
14. FATHER'S NAME			MIDDLE	LAST	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME		MIDDLE	LAST	
<i>Edward</i>				<i>Strunk</i>				<i>Route 1, 21713</i>			<i>Knobb</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Yes			WWII			235-18-7276			Mrs. Ruth Strunk - Same as #13			<i>Congestive Heart Failure</i>		<i>4 yrs.</i>	
IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												End Stage Renal Failure			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>7/31/84</i> , 19 <i>82</i> , to <i>8/1/84</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.															
22b. SIGNATURE <i>R.L. Kugler</i>			22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>8/1/84</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.L. Kugler MD</i>			22e. ADDRESS <i>100 Greeting Lane, Keedysville, Md</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 8/1/84			23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.			23d. LOCATION CITY OR TOWN			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board			25a. DATE REC'D. BY REGISTRAR AUG 6 1984			25b. REGISTRAR'S SIGNATURE <i>Suzanne Davidson-Randall</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place same in carbon adapter-Page 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked as Item 18 above any injury or other traumatic event (the medical examiner must be notified).

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE SUCIK CERTIFICATE OF DEATH										23130			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d DATE OF DEATH MONTH DAY YEAR			2d HOUR				
<i>Morton</i>					<i>Suerk</i>	8-8-84			2:25 PM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
<i>M</i>		<i>W</i>		<i>June 25, 1907</i>		77 YRS.							
7b BIRTHPLACE (COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. KIND OF BUSINESS OR INDUSTRY				
<i>Penn.</i>		<i>U.S.A.</i>				<i>Washington Co.</i>			<i>Coal Field</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NOTE: IF SUCH FACILITY, ONE STREET ADDRESS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13e. STREET ADDRESS ZIP CODE						
<i>Hagerstown</i>		<i>Wash. Co. Hospital</i>		<i>MINER</i>			<i>12162 Grant Shock Rd.</i>						
13c. STATE 13d. COUNTY		13e. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS ZIP CODE						
<i>Pa.</i>		<i>Franklin Green castle</i>											
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
<i>MARTIN - Suck</i>		<i>VERONA - Hone A VIK</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<i>NO</i>		<i>232-07-2217</i>		<i>Annie, E. Suck</i>		<i>Greencastle, Pa.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Card Register Failure</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Client Infectious lung Disease</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>8-8-84</i> , 19 <i>84</i> , to <i></i> , 19 <i></i> , that (I) (we) last saw the deceased alive on <i>8-8-84</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. DATE SIGNED <i>8-8-84</i>			
22c. DEGREE <i>Surgeon</i>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. L. Davidson</i>		22e. ADDRESS <i>382 South Crossland, Hagerstown Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8/11/84</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Brown's Mill Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Anttrim Twp., Franklin Co., Pa.</i>		23e. DATE REC'D. BY REGISTRAR <i>AUG 14 1984</i>		23f. REGISTRAR'S SIGNATURE <i>John Davidson - Rader</i>			
24. FUNERAL DIRECTOR <i>Moore, Nutter - Greencastle, Pa.</i>													
DHMH - 16 50M 4/83 (VRA 15, 4)													

A



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If item 21 is marked or Item 18 showing injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23131	
1 - STATE REGISTRAR		MAYNARD CALVIN THOMAS SR.				2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		10000XXXXX				10000XXXXX					8/3/84 3:50 PM
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS	
Male		White		MONTH Oct. DAY 5, YEAR 1903		80 yrs		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				Washington		MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Western Maryland Center		carpenter		lumber co.					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Md.		Frederick		Frederick				5928 Jefferson Blvd. 21701			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
UNKNOWN				Ellen Thomas		UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		216-07-7532		Ellen Thomas		Frederick, Md.		day			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8/3/84</u> to <u>8/3/84</u> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <u>8/3/84</u> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death.											
22b. SIGNATURE <u>Rose Marie Chan</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8/3/84</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROSE MARIE CHAN</u>		22e. ADDRESS <u>Western Maryland Center, Hagerstown</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 6, 1984		23c. NAME OF CEMETERY OR Crematory Gardens		23d. LOCATION City or Town Fred. Fred. Md.		COUNTY		State Maryland	
24. FUNERAL DIRECTOR NAME Thompson Funeral Home		ADDRESS Middletown, Md.		21769		25a. DATE REC'D. BY REGISTRAR 8/3/84		25b. REGISTRAR'S SIGNATURE <u>Sue Davidson Pendell</u>			

THE CANDIDATE READING - CRITICAL

CRITICAL POINTS IN THE READING

08 6001 .4 .300 section 6.1.1

points
no points

LOVINGLY observed 6.003

Saintsbury, Webster

1000000

1000000

Bill Webster's name was 2000000

1000000 1000000 1000000

1000000 1000000 1000000

1000000 1000000 1000000

1000000 1000000 1000000

1000000 1000000 1000000

1000000 1000000 1000000

1000000 1000000 1000000

1000000 1000000 1000000

1000000 1000000 1000000

1000000 1000000 1000000

1000000 1000000 1000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23132	
												REG. NO.	
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Louis Emory TUCKERMAN						August 18, 1984			M	
3. SEX male			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR February 27, 1913			6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington			MD.	
10. CITY OR TOWN OF DEATH Funkstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 302 North High Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher			12b. KIND OF BUSINESS OR INDUSTRY college			21734	
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Funkstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS N. High Street P. O. Box 2	
14. FATHER'S NAME FIRST MIDDLE LAST Louis A. Tuckerman			15. MOTHER'S MAIDEN NAME Mattie										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. W.W. II			17. INFORMANT Mrs. Ann R. Tuckerman, Funkstown, MD			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIOPULMONARY ARREST</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) <i>congestive heart failure</i>													
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>cerebral vasospastic disease</i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>Sept 29</i> CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this Hospital) attended the deceased from <i>Sept 29</i> to <i>Sept 29</i> , 19_____, that (I) (we) last saw the deceased alive on <i>Sept 29</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (do not) view the body after death.													
22b. SIGNATURE <i>D. Wooster</i>			22c. DEGREE			22d. DATE SIGNED 8/20/84							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>L. Dwight Wooster, M.D.</i>			22f. ADDRESS 1825 Howell Road, Hagerstown, MD 21740										
23a. BURIAL, CREMATION, REMOVAL (SPECIES) burial			23b. DATE Aug. 22, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery Baltimore, MD			23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740						25a. DATE REC'D. BY REGISTRAR AUG 27 1984			25b. REGISTRAR'S SIGNATURE <i>John W. Pendell</i>				

ЗМОН ГАЧІЛІМ

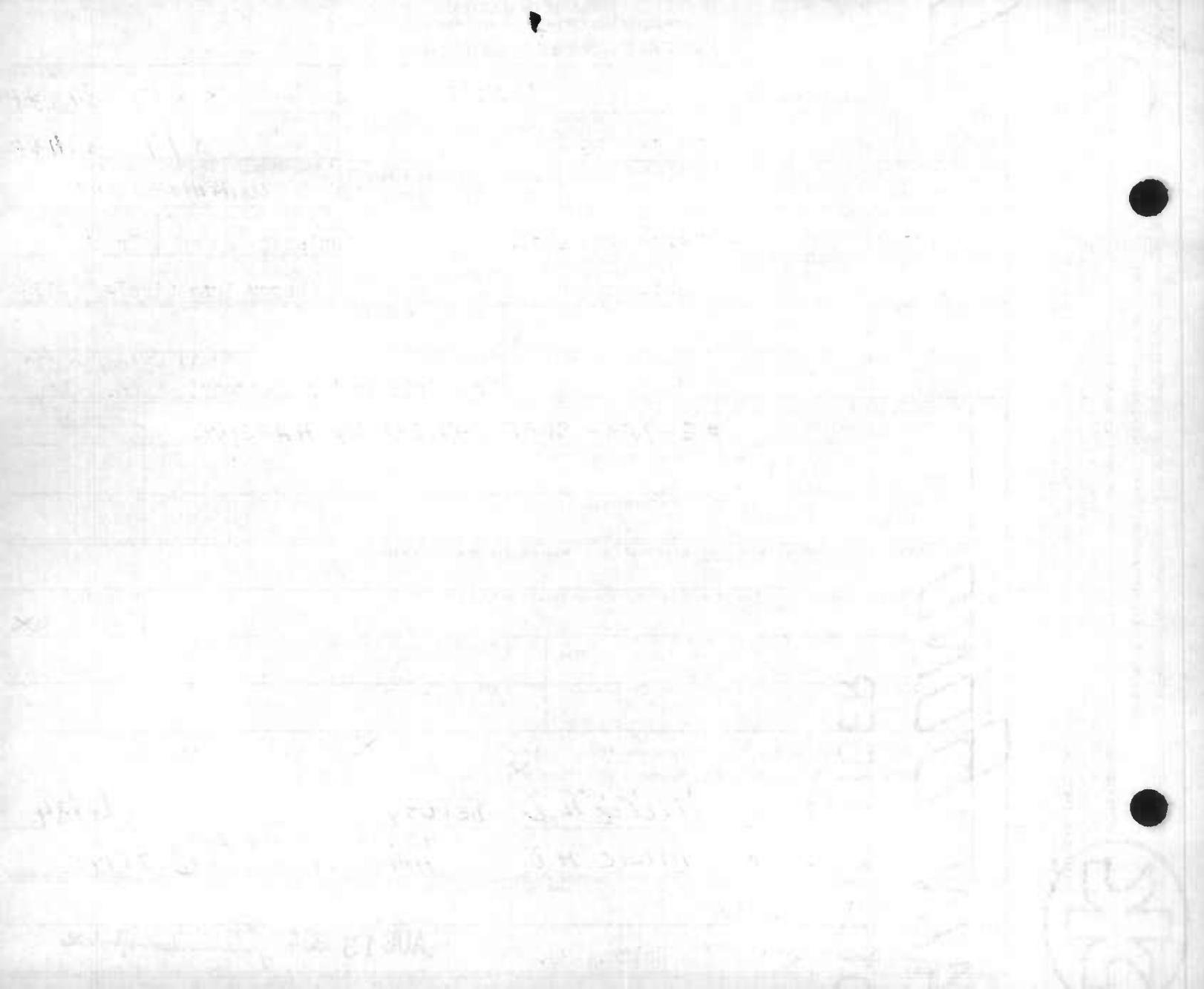
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
rejoined by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use as the Burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.IMPORTANT: If Item 21 is marked **B**, show any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23135							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
Charles William TURNER						August			1	1984		5:30am							
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male		Black		MONTH	DAY	YEAR	71			MONTHS	DAYS	HOURS	MIN.						
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.									
W.V.A.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington County												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown			Western Maryland Center									Laborer-Ret.							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE									
Md.		Wash.		Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			314 N. Prospect St. 21740									
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS											
Unknown					Sadie			Amelia Miner											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
NO			220-05-6208			Mrs. Marion Turner 314N. Prospect St.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic renal failure																			
DUE TO, OR AS A CONSEQUENCE OF (b) AS Hypertensive Nephropathy years																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																			
DUE TO, OR AS A CONSEQUENCE OF (c) Nephrosclerosis																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7-31 . 19 84 . to 8-1 . 19 84 . that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8-1 . 19 84 , and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death.																			
22b. SIGNATURE <i>See Dr. Porciuncula for Dr. Milaninia</i>												22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 8-1-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Milaninia, M.D.												22e. ADDRESS 1500 Penn. Ave., Hagerstown, MD 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 8/4/84			23c. NAME OF CEMETERY OR CREMATORY Riverview Cem.			23d. LOCATION TOWN WILLIAMSPORT Wash. Md. STATE										
24. FUNERAL DIRECTOR NAME <i>Dennis L. Davis Smithburg, Md.</i>												25a. DATE REC'D. BY REGISTRAR AUG 6 1984			25b. REGISTRAR'S SIGNATURE <i>Jeanne Davidson Pendell</i>				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 23134											
1 - STATE REGISTRAR																							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH ESTIMATED			2b. HOUR								
BERNARD									UCKO			8/7 1984			9:30PM								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR						
Male		White		12 2 98			85 yrs.							8/7 1984			#30PM						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?									8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH								
Germany												<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED			WASHINGTON								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Hagerstown			344 Cherry Tree Circle									Engineer			Truck								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS											
Md.						Hagerstown						344 Cherry Tree Circle			21740								
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST											
Unkn.																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)															16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Unkn.																		Mr. Ulric Breier			17 Whippoorwill Lane Westport, Conn.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) #E-953- SOFFOCATION BY HANGING															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																							
(c) _____																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (e).																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?											
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN														
									COUNTY			STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE		George Milic M.D. M.D. DEPUTY TITLE (SPECIFY)																					
EXAMINER'S NAME (TYPE OR PRINT)		40 MANOR DR #103 HAGERSTOWN-MD-21740 ADDRESS																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE										
Removal		8/8/84																					
24. FUNERAL DIRECTOR NAME		ADDRESS			Balto., Md.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE												
Anatomy Board								AUG 13 1984			John Davidson Pendell												



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												23135		
												REG. NO.		
1- STATE REGISTRAR			FIRST			MIDDLE			LAST			2a DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR		
1 DECEASED NAME (TYPE OR PRINT)			LOIS			IRENE			WAGAMAN			2b HOUR OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Aug. 19 84 A M		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c DATE PRONOUNCED DEAD August 1, 1984		
Female		White		9-6-1915		68 yrs.						2d HOUR MONTH DAY YEAR 10:00 A M		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			U.S.A.									Washington County		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Hagerstown			1724 Preston Road									Homemaker Home		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												21740		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Maryland		Washington		Hagerstown					1724 Preston Road					
14 FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
George L. Bonebrake			Hatti									Rowland		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			214-09-6241			S. Mitchell Wagaman same as L3								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suicide due to drug overdose (Code E-950) hours												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
(b) _____ DUE TO, OR AS A CONSEQUENCE OF														
(c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?					
									<input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE					
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER										DATE SIGNED 8/1/84		
EXAMINER'S NAME (TYPE OR PRINT)		580 Northern Avenue Hagerstown, Maryland 21740												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE			
Burial		8-4-1984		Rest Haven Cemetery			Hagerstown		Wash.		Md.			
24 FUNERAL DIRECTOR NAME		305 N. Potomac St.			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Gerald N. Minnich		Hagerstown, Maryland						AUG 8 1984		John T. Walker				
BP _____														
DHMH - 17														
(VR A15 ME (5))														
20M 4/82														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23130			
1 - STATE REGISTRAR			CARL ASBURY MIDDLE WATSON LAST WATSON							2a. DATE OF DEATH MONTH DAY YEAR 8 10 84		2b. HOUR 4:45 PM	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 11, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Piney Grove, MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY MD.							
10. CITY OR TOWN OF DEATH Funkstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 103 Stouffer Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanical		12b. KIND OF BUSINESS OR INDUSTRY Trucks							
13a. STATE MD.		13b. COUNTY Washington		13c. CITY OR TOWN Funkstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 103 Stouffer Ave. 21734					
14. FATHER'S NAME FIRST MIDDLE LAST DR. JOHN ASBURY WATSON		15. MOTHER'S MAIDEN NAME MARY E. "CRAWFORD" WATSON											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW 2		17. INFORMANT Mary N. Watson/Same as 13 e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years.							
DUE TO, OR AS A CONSEQUENCE OF (b) ORGANIC HEART DISEASE													
DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC VASCULAR DISEASE													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a DIABETES MELLITUS Type II.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from March 19 81 to August 19 84, that (I) (we) last saw the deceased alive on 8-8-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <i>Mary E. Money MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/14/84							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mary E. Money MD		22e. ADDRESS 1708 Oak Hill Ave, Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/14/84		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash. Md.		23e. COUNTY Wash.		STATE			
24. FUNERAL DIRECTOR NAME 1601 Pennsylvania Ave./Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR AUG 20 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendleton</i>									



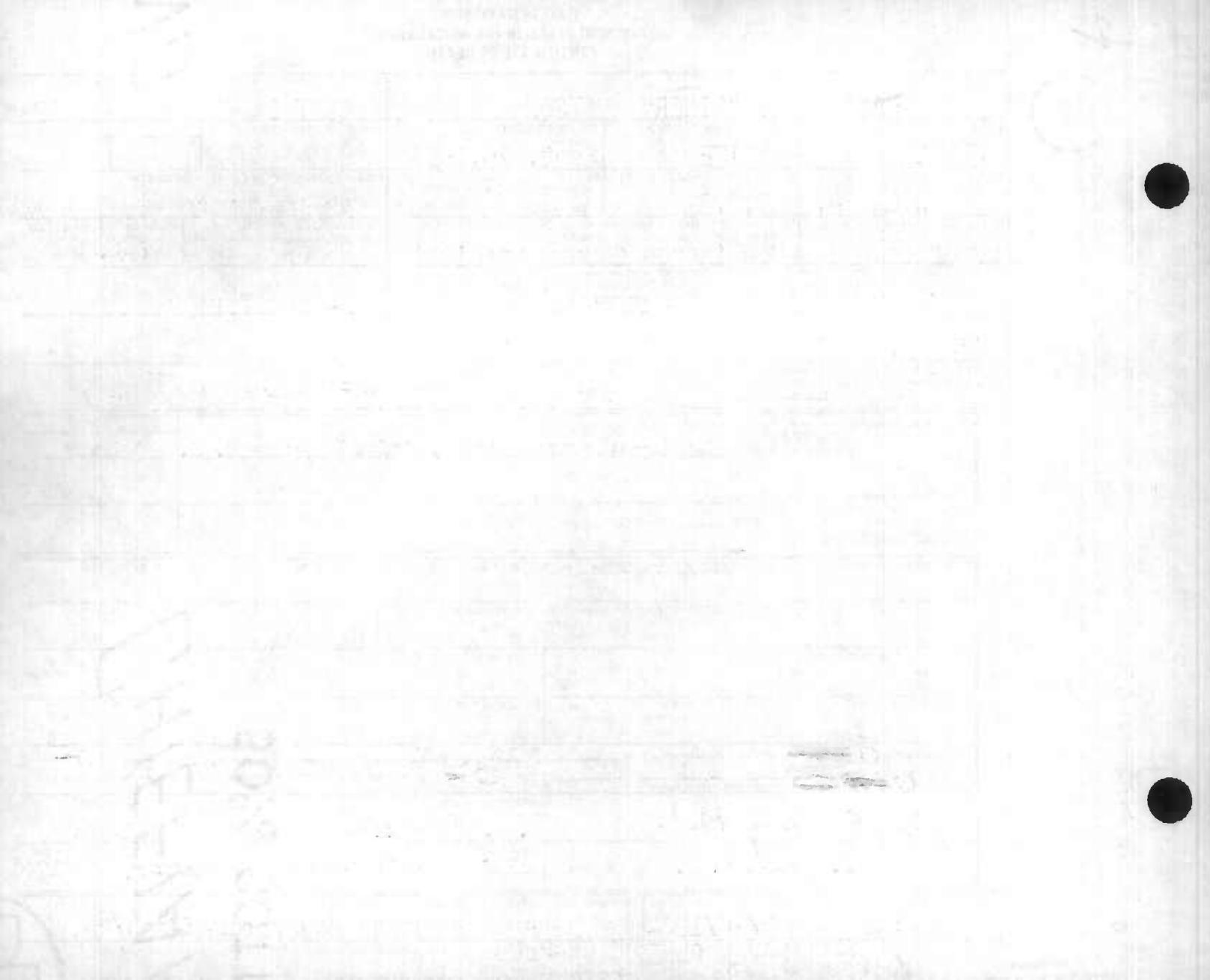
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23131			
										REG. NO.			
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			MARY LOUISE "NINER" WATSON						AUGUST 14, 1984			3:01 PM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE			WHITE			Sept. 20, 1915			68				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH	
FORT HILL, PA.			U.S.A.						WASHINGTON COUNTY MD.			Hagerstown Washington County Hospital	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY	
12. STATE			13b. COUNTY			13c. CITY OR TOWN			103 Stouffer Ave. 21734			Maryland Washington Funkstown Labour Aircraft	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS	
JOHN H. NINER			MATILDA "FOLK"			NO -----			194-03-0032 Jon Galley/201 Garden Spot Dr.,			Hagerstown, Md. 21740	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest, Probably Acute M. I.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour			
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that [REDACTED] attended the deceased from saw the deceased alive on above date and in my opinion death occurred on the date and hour and from the causes stated view the body after death.										5/12 1981 to present, that [REDACTED] lost			
22b. SIGNATURE <u>Mary E. Money, M.D.</u>										22c. DEGREE M. D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mary E. Money, M. D.										22e. ADDRESS 1708 Oak Hill Avenue Hagerstown, MD 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE BURIAL 8/16/1984			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown/Wash/Md.				
24. FUNERAL DIRECTOR NAME			REST HAVEN FUNERAL CHAPEL 1601 Penna. Ave. Hagerstown, Md.						25a. DATE REC'D. BY REGISTRAR AUG 20 1984			25b. REGISTRAR'S SIGNATURE [Signature]	

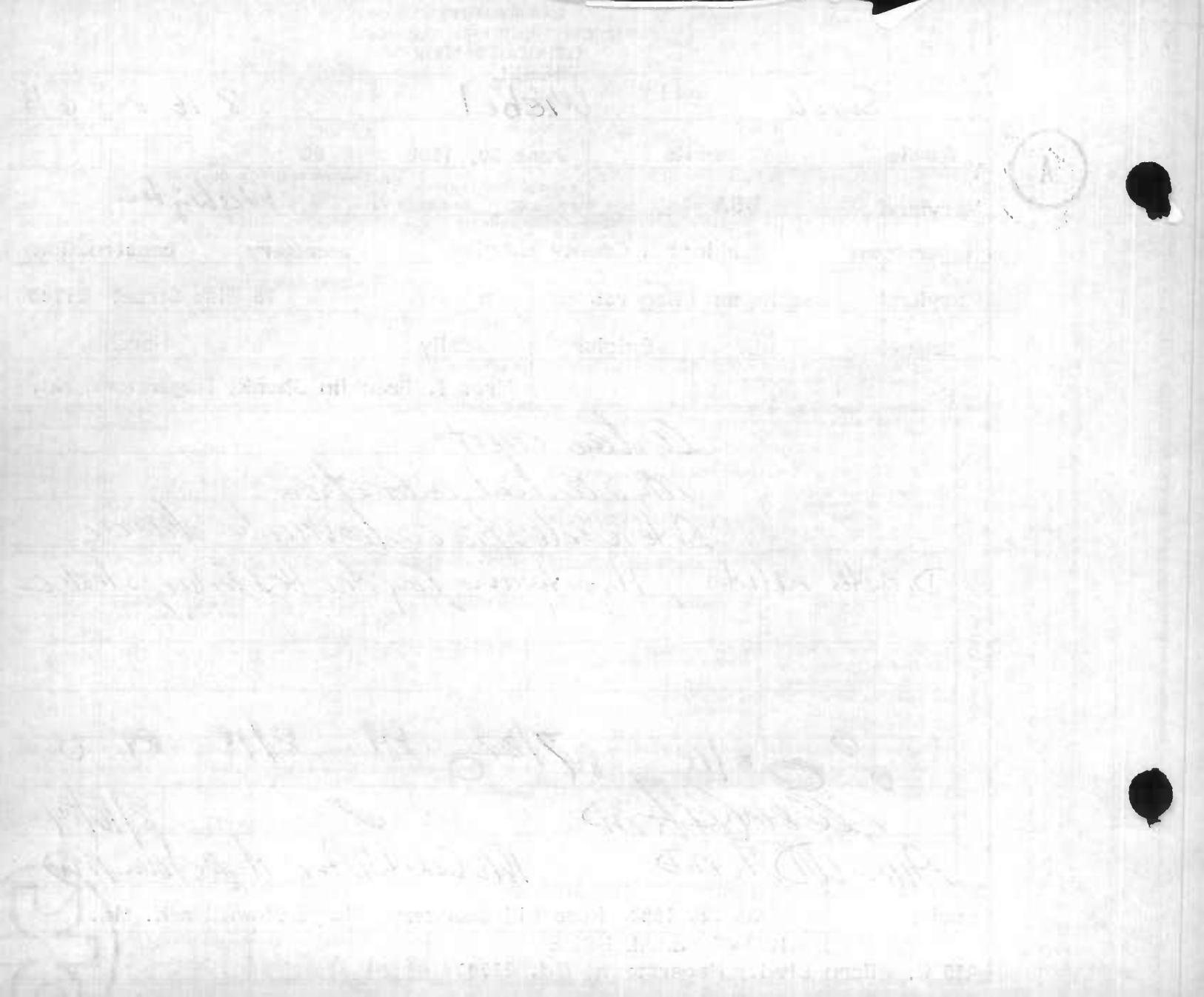


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-travel permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH WIEBEL												REG. NO. 23138
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Sarah</i>	MIDDLE <i>E</i> <i>Emilly</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>June 30, 1904</i>			6. AGE (IN YEARS LAST BIRTHDAY) 80		2a. DATE OF DEATH MONTH DAY YEAR <i>8 16 84</i>	2b. HOUR 6 15 AM	
3. SEX female		4. RACE white		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i>			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>secretary</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>construction</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>75 Wise Street 21740</i>			
14. FATHER'S NAME FIRST <i>Samuel</i>			MIDDLE <i>L.</i>		LAST <i>Spigler</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Emily</i>			MIDDLE <i></i>		LAST <i>Harsh</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS <i>Mrs. J. Franklin Shank, Hagerstown, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial infarction</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerotic cardiovascular disease</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Diabetes mellitus, Hypertension, Cystic fibrosis stroke</i>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>8/15/84</i> to <i>8/15/84</i> , that (I) we lost saw the deceased alive on <i>8/15/84</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (or not) (but did not) view the body after death.												
22b. SIGNATURE <i>Allen W. Wilson, M.D.</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>8/16/84</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Allen W. Wilson, M.D.</i>			22e. ADDRESS <i>1610 Oak Hill Ave Hagerstown MD</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>			23b. DATE <i>Aug. 20, 1984</i>			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Rose Hill Cemetery</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Md.</i>			
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>			25a. DATE REC'D. BY REGISTRAR <i>AUG 21 1984</i>			25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>						
415 E. Wilson Blvd., Hagerstown, Md. 21740												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

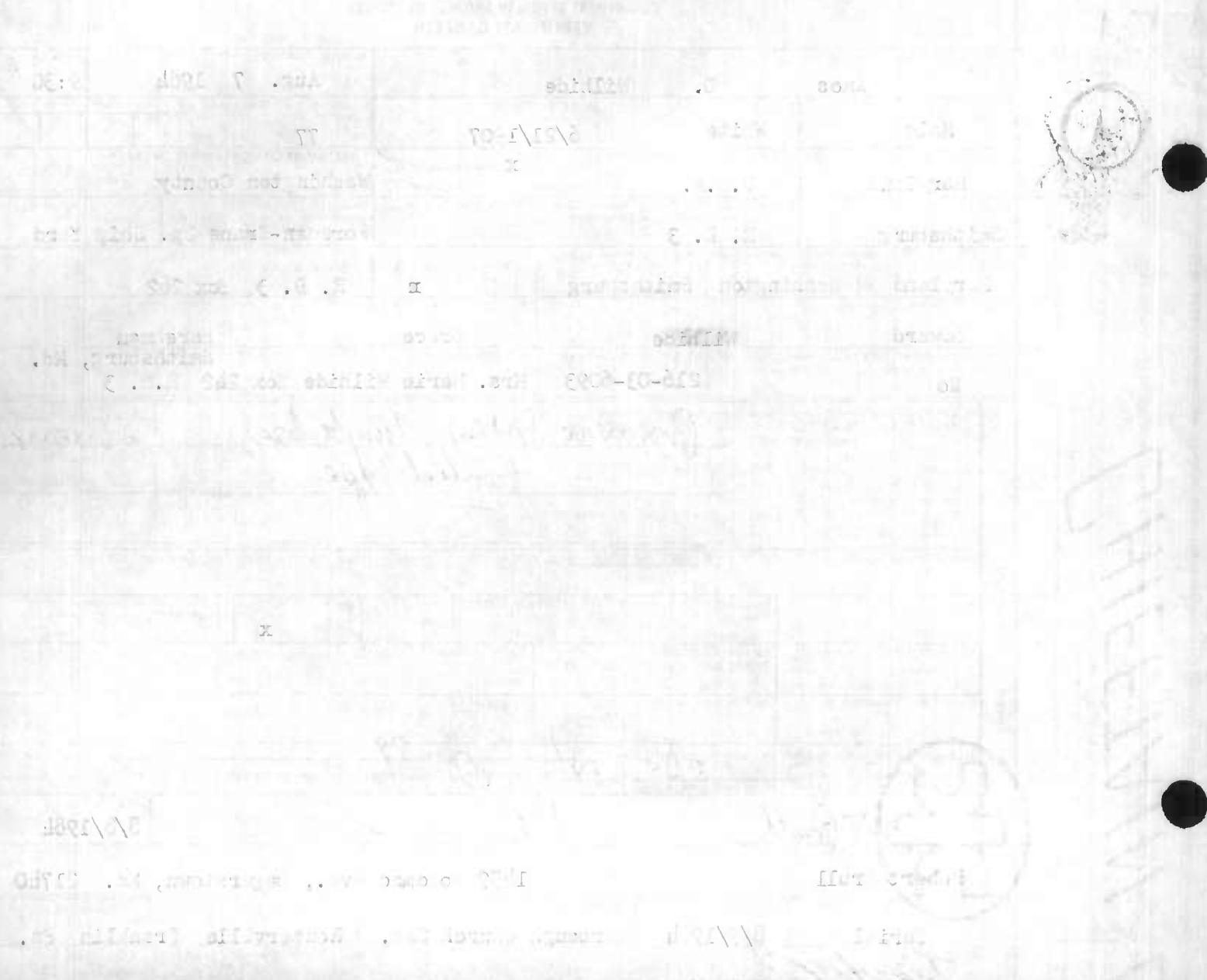
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23139

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	A				
Amos G. Wilhide						Aug. 7	1984		9:30	M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
Male		White		MONTH	DAY	YEAR	77								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		U.S.A.							Washington County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Smithsburg		R. D. 3		Foreman-Crane Op.		Ship Yard									
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
Maryland		Washington	Smithsburg	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R. D. 3 Box 242			81783						
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT	ADDRESS
Edward			Wilhide	Grace				No			216-03-6093			Mrs. Marie Wilhide	Smithsburg, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Progressive Systemic Amyloidosis, familial Type</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>25 years</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i></i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>5/24 1984</i> to <i>19 79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Robert Brull</i>		22c. DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>8/8/1984</i>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Brull		22e. ADDRESS 1459 Potomac Ave., Hagerstown, Md. 21740													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/9/1984		23c. NAME OF CEMETERY OR CREMATORIAL Harbaugh Church Cem.		23d. LOCATION CITY OR TOWN Rouzerville		COUNTY		STATE Franklin Pa.					
24. FUNERAL DIRECTOR <i>Robert Brull</i>		ADDRESS Waynesboro, Penna.		25a. DATE REC'D. BY REGISTRAR AUG 13 1984		25b. REGISTRAR'S SIGNATURE <i>Suzie Davidson-Pendleton</i>									



23 140

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Younker Harry C Younker, Jr.						August 31, 1984			M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		November 15, 1928			55 yrs.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		United States					Washington					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Washington County Hospital		Self-Employed			Salvage					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland		Washington		Hancock						Route # 1 21750		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Harry C. Younker, Sr.		Lula Moore										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			236 44 4797			Helen A. Younker			Rt. 1 Hancock, Md. 21750			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>due advanced</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastatic sq. cell carcinoma of larynx.</u>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>8/31/84</u> 19 <u>84</u> , to <u>8/31/84</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>8/31/84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>BIBHAS C. BANDY</u>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>363, S. Cleveland Ave</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
BIBHAS C. BANDY		363, S. Cleveland Ave										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. STATE			
Burial		09/04/1984		Greenlawn Mem. Park			Williamsport, Washington, Md.					
24. FUNERAL DIRECTION HOME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Burial Home, Hancock MD 21750					SEP 7 1984			John Davidson, Rendell				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 2 should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____
DHMH - 16 50M 4/83
(VRA 15, 4)

